HM LIFE INSURANCE COMPANY

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Southern Methodist University

Travel Abroad

CERTIFICATE OF COVERAGE

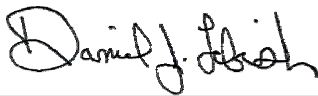
BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE

POLICY NO. HM-3029-A-09 ("the Policy")

Participating Organization or Institution:	**Southern Methodist University**
Participating Organization's or Institution's Effective Date:	May 1, 2009
Eligible Participant:	See Identification Card Issued to Participant
Eligible Dependents:	See Identification Card Issued to Participant
Coverage Start Date:	See Identification Card Issued to Participant

This Certificate refers to an Eligible Participant and an Eligible Dependent as a "Covered Person," and to **HM Life Insurance Company** as "Insurer." The Policy will be administered on behalf of the Insurer by the "Administrator," Worldwide Insurance Services, Inc., aka "HTH Worldwide".

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



President

Secretary

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SECTION 1
SCHEDULE OF BENEFITS
ELIGIBLE CLASSES

The Classes eligible for coverages available under the Policy are shown below.

__X__ Class I: Study Abroad Student Eligible Participants enrolled in the educational institution's sponsored or approved study abroad program and their Eligible Dependents.

__X__ Class II Study Abroad Staff Eligible Participants providing direct support to the educational institution's sponsored or approved study abroad program at its Country of Assignment location and their Eligible Dependents.

All benefits and limits are stated per Covered Person

SCHEDULE OF BENEFITS
TABLE 1

	Limits Eligible Participant	Limits Spouse	Limits Child
COVERAGE A – MEDICAL EXPENSES			
Lifetime Maximum Benefit	$2,500,000	$2,500,000	$2,500,000
Policy Year Maximum Benefits	$250,000	$250,000	$250,000
Maximum Benefit per Injury or Sicknesses	$250,000	$250,000	$250,000
Deductible	$0 per Injury or Sickness	$0 per Injury or Sickness	$0 per Injury or Sickness
COVERAGE B – ACCIDENTAL DEATH AND DISMEMBERMENT	Maximum Benefit: Principal Sum up to $50,000	Maximum Benefit: Principal Sum up to $5,000	Maximum Benefit: Principal Sum up to $1,000
COVERAGE C – REPATRIATION OF REMAINS	Maximum Benefit up to $50,000	Maximum Benefit up to $50,000	Maximum Benefit up to $50,000
COVERAGE D – MEDICAL EVACUATION	Maximum Benefit for all Evacuations up to $100,000	Maximum Benefit for all Evacuations up to $100,000	Maximum Benefit for all Evacuations up to $100,000
COVERAGE E – BEDSIDE VISIT	Up to a Maximum Benefit of $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	Up to a Maximum Benefit of $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	Up to a Maximum Benefit of $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

SCHEDULE OF BENEFITS
TABLE 2

COVERAGE A – MEDICAL EXPENSES	Indemnity Plan Limits
Physician Office Visits	100% of Reasonable Expenses
Inpatient Hospital Services	100% of Reasonable Expenses
Hospital and Physician Outpatient Services	100% of Reasonable Expenses

SCHEDULE OF BENEFITS
TABLE 3
COVERAGE A – MEDICAL EXPENSE BENEFITS

BENEFITS LISTED BELOW ARE SUBJECT TO

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

2. TABLE 2 PLAN TYPE LIMITS (INDEMNITY)

MEDICAL EXPENSES	COVERED PERSON
Maternity Care for a Covered Pregnancy	Reasonable Expenses Conception must have occurred while the Covered Person was insured under the Policy
Inpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to $2,500 maximum per lifetime for a maximum period of 30 days per lifetime
Outpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to $500 Maximum per Lifetime
Treatment of specified therapies, including acupuncture and Physiotherapy	Reasonable Expenses up to $5,000 Maximum combined total for Inpatient and Outpatient care, up to 30 days immediately following the attending Physician's release for rehabilitation following a covered Hospital confinement or surgery per Policy Year.
Therapeutic termination of pregnancy	Reasonable Expenses up to $500 Maximum per Policy Year
Routine nursery care of a newborn child of a covered pregnancy	Reasonable Expenses up to $500 Maximum per Policy Year
Repairs to sound, natural teeth required due to an Injury	100% of Reasonable Expenses up to $500 per Policy Year Maximum
Outpatient prescription drugs including prescription oral contraceptives and devices	100% of actual charge

SECTION 2
DESCRIPTION OF COVERAGES
COVERAGE A – MEDICAL EXPENSES

A. **What the Insurer Pays for Covered Medical Expenses:** If a Covered Person incurs expenses while insured under the Policy due to an Injury or a Sickness, the Insurer will pay the Reasonable Expenses for the Covered Medical Expenses listed below. All Covered Medical Expenses incurred as a result of the same or related cause, including any Complications, shall be considered as resulting from one Sickness or Injury. The amount payable for any one Injury or Sickness will not exceed the Maximum Benefit for the Eligible Participant or the Maximum Benefit for an Eligible Dependent stated in Coverage A – Medical Expenses of Table 1 of the Schedule of Benefits. Benefits are subject to the Deductible Amount, Coinsurance, Co-payments, and Maximum Benefits stated in the Schedule of Benefits, specified benefits and limitations set forth under Covered Medical Expenses, the General Policy Exclusions, the Pre-Existing Condition Limitation, and to all other limitations and provisions of the Policy.

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

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

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

1. **Physician office visits.**

2. **Hospital Services:** Inpatient Hospital services and Hospital and Physician Outpatient services consist of the following: Hospital room and board, including general nursing services; medical and surgical treatment; medical services and supplies; Outpatient nursing services provided by an RN, LPN or LVN; local, professional ground ambulance services to and from a local Hospital for Emergency Hospitalization and Emergency Medical Care; x-rays; laboratory tests; prescription medicines; artificial limbs or prosthetic appliances, including those which are functionally necessary; the rental or purchase, at the Insurer's option, of durable

medical equipment for therapeutic use, including repairs and necessary maintenance of purchased equipment not provided for under a manufacturer's warranty or purchase agreement.

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

If Tests and X-rays are the result of a Physician Office Visit or of Hospital and Physician Outpatient Services there is no additional Copayment for these Tests or X-rays. However, if there is neither a Physician Office Visit nor Hospital or Physician Outpatient Services delivered, the Hospital and Physician Outpatient Services Copayment applies.

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

1. **Pregnancy:** The Insurer will pay the actual expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these, except to the extent shown in the Schedule of Benefits. Conception must have occurred while the Covered Person was insured under the Policy. Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:
   a) a minimum of 48 hours of inpatient care following a vaginal delivery; or
   b) a minimum of 96 hours of inpatient care following delivery by cesarean section.

   If the physician, in consultation with the mother, determine that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's office, as determined by the physician in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:
   a) Parental education;
   b) Assistance and training in breast or bottle feeding; and
   c) Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

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

3. **Mammography screening, when screening for occult breast cancer is recommended by a Physician:** Coverage is as follows:
   a) female Covered Persons are allowed one baseline mammogram;
   b) female Covered Persons are allowed a screening mammogram annually; (Mammograms are not subject to the deductible provision.)

4. **Colorectal cancer screenings:** Colorectal screenings shall be in compliance with the American Cancer Society colorectal cancer screening guidelines.

5. **Diabetic Supplies/Education:** Coverage shall be provided for equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a health care professional legally authorized to prescribe such item.

6. **Prostate screening tests:** Coverage shall be provided for Prostate Specific Antigen tests and the Office Visit associated with this test when ordered by the Covered Person's Physician or nurse practitioner.

7. **Child Preventive and Primary Care Services:** Coverage for preventive and primary care services, including physical examinations, measurements, sensory screening, neuro-psychiatric evaluation, and development screening, which coverage shall include unlimited visits for children up to the age 12 years, and 3 visits per year for minor children ages 12 years up to 18 years of age, and 1 visit per year for covered children 19 and 20 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, newborn hearing screenings, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

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

SECTION 3
COVERAGE B – ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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

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

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

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

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

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

SECTION 4
COVERAGE C – REPATRIATION OF REMAINS BENEFIT

If Covered 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 Covered Person is Hospital Confined on the Termination Date, eligibility for this benefit continues until the earlier of the date the Covered 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 Plan Administrator before the body is prepared for transportation.

SECTION 5
COVERAGE D – MEDICAL EVACUATION BENEFIT

If an Covered Person is involved in an accident or suffers a sudden, unforeseen illness requiring emergency medical services, while traveling outside of his/her home country, and adequate medical facilities are not available, the Administrator will coordinate and pay for a medically-supervised evacuation, up to the Maximum Limit shown in the Schedule of Benefits, to the nearest appropriate medical facility. This medically-supervised evacuation will be to the nearest medical facility only if the facility is capable of providing adequate care. The evacuation will only be performed if adequate care is not available locally and the Injury or Sickness requires immediate emergency medical treatment, without which there would be a significant risk of death or serious impairment. The determination of whether a medical condition constitutes an emergency and whether area facilities are capable of providing adequate medical care shall be made by physicians designated by the Administrator after consultation with the attending physician on the Covered 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 Covered 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 Covered Person is a minor or if the Covered 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 Covered 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 Covered Person's point of origin, if necessary.

SECTION 6
COVERAGE E – BEDSIDE VISIT BENEFIT

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

SECTION 7
LIMITATIONS

A. Pre-Existing Condition Limitation

The Insurer does pay benefits for loss due to a Pre-existing Condition.

B. Limitation of Maternity Coverage.

The Policy does not pay benefits for maternity coverage unless conception occurred while the Covered Person was insured under the Policy.

SECTION 8
GENERAL POLICY EXCLUSIONS

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

1. Expenses incurred in excess of Reasonable Expenses.
2. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health.
3. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury.
4. Surgery for the correction of refractive error and services and prescriptions for eye examinations, eye glasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury.
5. Plastic or cosmetic surgery, unless they result directly from an Injury which necessitated medical treatment within 24 hours of the Accident.
6. Elective termination of pregnancy.
7. Expenses incurred as a result of pregnancy that is not covered.
8. For diagnostic investigation or medical treatment for infertility, fertility, or birth control.
9. Expenses incurred for Injury resulting from the Covered Person's being legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the Accident occurs. This exclusion does not apply to the Medical Evacuation Benefit, to the Repatriation of Remains Benefit and to the Bedside Visit Benefit.
10. Voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Physician. This exclusion does not apply to the Medical Evacuation Benefit, to the Repatriation of Remains Benefit and to the Bedside Visit Benefit.
11. Organ or tissue transplant.
12. Participating in an illegal occupation or committing or attempting to commit a felony.
13. For treatment, services, supplies, or Confinement in a Hospital owned or operated by a national government or its agencies. (This does not apply to charges the law requires the Covered Person to pay.)
14. 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.
15. The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Policy.
16. Expenses incurred within the Covered Person's Home Country, except for a non-US participant on a school sanctioned study abroad program and the time spent in their home country is less than 30 days.
17. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction's of teeth, TMJ dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia.
18. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
19. Diagnosis and treatment of acne and sebaceous cyst.
20. Outpatient treatment for specified therapies including, but not limited to, Physiotherapy and acupuncture which does not follow a covered Hospital Confinement or surgery.
21. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.
22. Self-inflicted Injuries while sane or insane; suicide, or any attempt thereat while sane or insane. This exclusion does not apply to the Medical Evacuation Benefit, to the Repatriation of Remains Benefit and to the Bedside Visit Benefit.
23. Loss due to war, declared or undeclared; service in the armed forces of any country or international authority; riot; or civil commotion.

24. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.
25. Loss arising from
    a. participating in any professional sport;
    b. scuba diving, hang gliding, parachuting or bungee jumping.
26. Medical Treatment Benefits provision for loss due to or arising from a motor vehicle Accident if the Covered Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.
27. Under the Accidental Death and Dismemberment provision, for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.
28. Services or supplies that the Insurer considers to be Experimental or Investigative.

SECTION 9
DEFINITIONS

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

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

Age means the Covered Person's attained age.

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

Ambulatory Surgical Facility means an establishment which may or may not be part of a Hospital and which meets the following requirements:
1. Is in compliance with the licensing or other legal requirements in the jurisdiction where it is located;
2. Is primarily engaged in performing surgery on its premises;
3. Has a licensed medical staff, including Physicians and registered nurses;
4. Has permanent operating room(s), recovery room(s) and equipment for Emergency Medical Care; and
5. Has an agreement with a Hospital for immediate acceptance of patients who require Hospital care following treatment in the ambulatory surgical facility.

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

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

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

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

Covered Medical Expense means an expense actually incurred by or on behalf of a Covered Person for those services and supplies which are:
1. administered or ordered by a Physician;
2. Medically Necessary to the diagnosis and treatment of an Injury or Sickness;
3. are not excluded by any provision of the Policy; and incurred while the Covered Person's insurance is in force under the Policy, except as stated in the Extension of Benefits provision.

A Covered Medical Expense is deemed to be incurred on the date such service or supply which gave rise to the expense or charge was rendered or obtained. Covered Medical Expenses are listed in Table 3 and described in Section 2.

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

Deductible Amount means the dollar amount of Covered Medical Expenses which must be incurred as an out-of-pocket expense by each Covered Person on a per Injury or per Sickness basis before certain benefits are payable under the Policy. The Deductible Amounts are stated in the Schedule of Benefits.

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

Durable Medical Equipment means medical equipment which:

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

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

Eligible Dependent: An Eligible Dependent may be the Eligible Participant's lawful spouse and/or his/her unmarried children under age 19 who are chiefly dependent upon the Eligible Participant for support and maintenance. The term "child/children" includes a natural child, a legally adopted child, a stepchild, and a child who is dependent on the Eligible Participant during any waiting period prior to finalization of the child's adoption. The Eligible Dependent is one who

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

Eligible Participant means a person who:

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

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

Hospital means a facility that:

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

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

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

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

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

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

Medically Necessary 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 Covered Person is receiving or the severity of the Covered 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.

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

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

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

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage, and medical benefits coverage in group, group-type and individual automobile "no fault" and "traditional fault" type contracts. It does not include student accident-type coverage.
2. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to states for medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess of those of any private program or other non-governmental program.

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

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

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

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

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

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

Reasonable Expense means the normal charge of the provider, incurred by the Covered Person, in the absence of insurance,

1. for a medical service or supply, but not more than the prevailing charge in the area for a like service by a provider with similar training or experience, or
2. for a supply which is identical or substantially equivalent. The final determination of a reasonable and customary charge rests solely with the Insurer.

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

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

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

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

12:00:01 a.m. means 12:00:01 Eastern Prevailing Time in Washington, DC.

SECTION 10
EXTENSION OF BENEFITS

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

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

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

SECTION 11
COORDINATION OF BENEFITS (COB)

Some people have health care coverage through more than one medical insurance plan at the same time. COB allows these plans to work together so the total amount of all benefits will never be more than 100 percent of the allowable expenses during any policy year. This helps to hold down the costs of health coverage.

COB does not apply to life insurance, accidental death and dismemberment, or disability benefits.

The term "plan" applies separately to each policy, contract agreement or other arrangements for benefits or services. The term "plan" also applies separately to that part of any policy, contract, agreement or other arrangements for benefits or services that coordinates its benefits with other plans and to that part that does not.

When a plan provides benefits in the form of services rather than cash payment, the reasonable cash value of each service rendered will be considered to be both: (1) an allowable expense; and (2) a benefit paid. This provision may not be applied to claims less than $250, but if additional liability is incurred to raise the small claim above $250, the entire liability may be included in the coordination of benefits computations.

Effect on Benefits. Plans use COB to decide which plan should pay first for a covered expense. If this primary plan's payment is less than the charge for the allowable expense, then the second-paying (secondary) plan will apply its benefit payment to the balance.

The following rules will be used to establish the order of benefit determination:

1. A plan which does not have a COB provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses the claim is based as other than a dependent will be determined before the benefits of a plan which covers the person as a dependent. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
   a. First, benefits of a plan covering persons as an employee, member, or subscriber.
   b. Second, benefits of a plan of an active worker covering persons as a dependent.
   c. Third, Medicare benefits.
3. The benefits of a plan that covers a person for whom a claim is made as a dependent child will be determined under the following rules:
   a. When the parents are married: the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs earlier in the calendar year will be determined before the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs later in the calendar year.
   b. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
   c. If the plans do not agree on the order of benefit rules because the other plan does not have the rule described in this section, but has a rule based upon the gender of the parent, the rule in the other plan will determine the order of benefits.
   d. When the parents are separated or divorced and the parent with custody has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
   e. When the parents are divorced and the parent who has custody of the child has remarried: (a) the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the step-parent; and (b) the benefits of a plan that covers the child as a dependent of the step-parent will be determined before the benefits of a plan that covers the child as a dependent of the parent without custody.
   f. Despite (2) and (3) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefit payment of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefit payment of any other plan that covers the child as a dependent child.

4. The benefits of a plan that covers a person as a primary insured who is neither laid off nor retired, or as that primary insured's dependent, are determined before those of a plan that covers that person as a laid off or retired primary insured or as that primary insured's dependent. This rule will not apply if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits.

5. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another plan, the following will be the order of benefit determination:
   a. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
   b. Second, the benefits under the continuation coverage. If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

6. When rules 2 through 5 do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses the claim is based for the longer period of time will be determined before the benefits of a plan which has covered the person the shorter period of time.

Facility of Payment. If another plan makes a benefit payment that should have been made by the Insurer, the Insurer has the right to pay the other plan any amount the Insurer deems necessary to satisfy the Insurer's obligation under these COB rules.

Right of Recovery. If the amount of the Insurer's benefit payment is more than the amount needed to satisfy the Insurer's obligation under these COB rules, the Insurer has the right to recover the excess amount from: (A) any persons to or for whom, or with respect to whom, the payments were made; (B) any insurance companies; or (C) any other organizations.

Right to Receive and Release Necessary Information. In order to carry out these COB rules:
1. The Insurer has the right, without the consent of or notice to any person, to exchange information with any person, insurance company or organization, as the Insurer deems necessary; and
2. Any person claiming benefits under this plan must give the Insurer any information necessary to carry out this provision.

SECTION 12
ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE

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

Enrollment for Coverage: An Eligible Participant will be eligible for coverage under the Policy subject to the particular types and amounts of insurance as specified in his/her enrollment form. If dependent coverage is offered by the Policyholder, an Eligible Participant may also enroll his/her Eligible Dependents for coverage on the later of:
1. The effective date of his/her insurance; or
2. Within 31 days from the date on which the Dependent arrives in the Country of Assignment.

When an Eligible Participant's Coverage Starts: Coverage for an Eligible Participant starts at 12:00:01 a.m. on the latest of the following:
1. The effective date of the Policy; or
2. The effective date shown on the Insurance Identification Card, if any;
3. The date the requirements in Section 1 – Eligible Classes are met; or
4. The date the premium and completed enrollment form, if any, are received by the Insurer or the Administrator.

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

When an Eligible Participant's Coverage Ends: Coverage for an Eligible Participant will automatically terminate on the earliest of the following dates:
1. The date the Policy terminates;
2. The date of which the Eligible Participant ceases to meet the Individual Eligibility Requirements;
3. The end of the term of coverage specified in the Eligible Participant's enrollment form, if any, including any requested extension;
4. The date the Eligible Person leaves the Country of Assignment for his/her or her Home Country;
5. The date the Eligible Participant requests cancellation of coverage (the request must be in writing); or
6. The premium due date for which the required premium has not been paid, subject to the Grace Period provision.

Any unearned premium will be returned upon request, but returned premium will only be for the number of full months of the unexpired term of coverage, less any administrative fees. Premium will be refunded in full or pro-rated if it is later determined that the Covered Person is not eligible for coverage or if the enrollment form contained inaccurate or misleading information.

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

When an Eligible Dependent's Coverage Starts: An Eligible Dependent may only be added or dropped from coverage in the case of a qualifying event defined as marriage, death, loss of coverage, divorce, entry into or departure from the Country of Assignment. An Eligible Dependent's coverage starts at 12:00:01 a.m. on the latest of the following:

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

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

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

1. The date the Policy terminates; or
2. The date the Eligible Participant is no longer covered under the Policy;
3. 11:59:59 p.m. on the date he or she departs the Country of Assignment for his or her Home Country;
4. The date the Covered Person requests cancellation of coverage (the request must be in writing);
5. The premium due date for which the required premium has not been paid, or
6. The date on which the dependent ceases to meet the eligibility requirements.

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

SECTION 13
COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN

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

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

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

Expenses for routine nursery care means the charges of a Hospital and attending Physician for the care of a healthy newborn infant while Confined. Care includes treatment of standard neo-natal jaundice.

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

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

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

SECTION 14
CLAIM PROVISIONS

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

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

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

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

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

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

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

All benefits payable under the Policy shall be payable to the Insured or to his/her designated beneficiary or beneficiaries, or to his/her estate. If the Insured is a minor, benefits may be payable to his/her parents, guardian, or other person actually supporting him/her, or to a person or persons upon whom such minor is chiefly dependent upon for support and maintenance.

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

SECTION 15
GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

Subrogation: If the Covered Person suffers an Injury or Sickness through the act or omission of another person, and if benefits are paid under the Policy due to that Injury or Sickness, then to the extent the Covered Person recovers for the same Injury or Sickness from a third party, its insurer, or the Covered Person's uninsured motorist insurance, the Insurer will be entitled to a refund of all benefits the Insurer has paid from such recovery. Further, the Insurer has the right to offset subsequent benefits payable to the Covered Person under the Policy against such recovery.

The Insurer may file a lien in a Covered Person's action against the third party and have a lien upon any recovery that the Covered Person receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. The Insurer shall have a right to recovery of the full amount of benefits paid under the Policy for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Covered Person. The Insurer will not be responsible for the Covered Person's attorneys' fees or other cost.

Upon request, the Covered Person must complete the required forms and return them to the Insurer or to the Administrator. The Covered Person must cooperate fully with the Insurer in asserting his/her right to recover. The Covered Person will be personally liable for reimbursement to the Insurer to the extent of any recovery obtained by the Covered Person from any third party. If it is necessary for the Insurer to institute legal action against the Covered Person for failure to repay the Insurer, the Covered Person will be personally liable for all costs of collection, including reasonable attorneys' fees.

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

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

Grievance Procedures: If the Covered 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 Covered 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 Covered Person's written request, the Insurer will review the claim and arrive at a determination.

If the matter is still not resolved to the Covered 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 Covered Person will be informed, in writing, of the Insurer's final decision.

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

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

HM Life Insurance Company
120 Fifth Avenue
Fifth Avenue Place
Pittsburgh, PA 15222

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 Covered Person and the Insurer will be acknowledged in writing, along with a description of how the Insurer propose to resolve the grievance.

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

HM LIFE INSURANCE COMPANY

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222
1-800-328-5433
Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

Endorsement to Certificate
State of Texas

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

By attachment of this Endorsement, it is understood and agreed that the insurance under the Participation Certificate/certificate is amended, with respect to covered persons residing in the state of Texas, as follows:

1. Table 2, Schedule of Benefits, is amended to provide that if covered services are not available through preferred providers within the service area, non-preferred providers shall be reimbursed at the same percentage level of reimbursement as preferred providers. However, this shall not apply solely because a Covered Person resides out of the service area and chooses to receive services from providers other than preferred providers for the Covered Person's own convenience.

2. Section 9, Definitions, is amended to include the following definitions:

   Calendar Year means the period from January 1 through December 31 of the same year.

   Complications of Pregnancy means conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsis, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

   Non-Preferred Provider means a Hospital, Physician, or other health care provider who has not agreed to participate in the PPO.

   Non-Preferred Provider Organization (PPO) means a network(s) of Providers who have not agreed to participate in the PPO.

   Preferred Provider Organization Service Area means the entire State of Texas.

3. The definition of "**Congenital Condition**", found in Section 9, Definitions, is amended to delete the word, "functional".

4. The definition of "**Emergency Hospitalization and Emergency Medical Care**", in Section 9, Definitions, is deleted and replaced with the following:

   Emergency Hospitalization and Emergency Medical Care means hospitalization or medical care provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including, but not limited to, severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in:

   (a) placing the patient's health in serious jeopardy;
   (b) serious impairment to bodily functions;
   (c) serious dysfunction of any bodily organ or part;
   (d) serious disfigurement;
   (e) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

5. The definition of **"Eligible Dependent",** in Section 9, Definitions, is deleted and replaced with the following:

   "Eligible Dependent" means the Eligible Participant's:

   (a) married spouse;
   (b) unmarried child or stepchild who is not eligible for medical coverage as an Eligible Participant under this Participation Certificate or any other group Participation Certificate and who:
       (1) is less than age 25; or
       (2) becomes incapable of self-support because of mental retardation or physical handicap prior to reaching the limiting age for dependent children. The child must be dependent on the Eligible Participant for support and maintenance. The Insurer must receive proof of incapacity within 31 days after coverage would otherwise terminate. Then, coverage will continue for as long as the Eligible Participant's insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 25.

The term Eligible Dependent also includes:

(1) a grandchild of the Eligible Participant, who is less than age 25 and is a dependent of the Eligible 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 Eligible Participant for federal tax purposes);
(2) 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);
(3) 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.

6. The definition of "Other Plan", found in Section 9, Definitions, is deleted in its entirety.

7. The definition of "Pre-Existing Condition", found in Section 9, Definitions, is deleted in its entirety and replaced with the following:

   Pre-Existing Condition means a disease or physical condition of a Covered Person, not otherwise excluded from the Covered Person's coverage by name or specific description effective on the date of the Covered Person's loss, for which medical advice or treatment was received by the Covered Person during the 12 months prior to the effective date of coverage.

8. The definition of "**Sickness**" found in Section 9, Definitions, is amended to include "complication of pregnancy".

9. Section 2, Description of Coverage, is amended as follows:

   (a) Item 1 regarding Pregnancy, is amended to refer to "normal pregnancy", delete the reference to "miscarriage" and to include the following:

   Coverage shall be provided for timely postdelivery care. That care may be provided to the mother and child by a Physician, registered nurse, or other appropriate licensed health care provider and may be provided at:
   (1) the mother's home, a health care provider's office, or a health care facility; or
   (2) another location determined to be appropriate under rules adopted by the commissioner.

   For purposes here, "postdelivery care" means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. The timeliness of the care shall be determined in accordance with recognized medical standards for that care.

   (b) Item 3 regarding Mammography screening, is deleted in its entirety and replaced with the following:

   Mammography screening: Coverage shall include expenses incurred for an annual screening by low-dose mammography for the presence of occult breast cancer for a female Covered Person 35 years old or older. As used here, "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including the X-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

   (c) Item 4 regarding Colorectal Cancer Screenings, is deleted in its entirety and replaced with the following:
   Colorectal cancer screenings: Coverage shall include expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer for each Covered Person who is 50 years of age or older and at normal risk for developing colon cancer. Benefits shall include: (1) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every 5 years; or (2) a colonoscopy performed every 10 years.

   (d) Item 5, regarding Diabetic Supplies/Equipment, is deleted and replaced with the following:
   Diabetic Supplies/Equipment and Self-Management Education coverage shall include equipment, supplies and related services for the treatment of Type I, Type II and gestational diabetes when recommended or prescribed by a Physician for a Covered Person or the caretaker of a Covered Person:

   (1) visual reading and urine testing strips and tablets which test for glucose, ketones and protein;
   (2) insulin pumps, both external and implantable, and associated appurtenances, which include: (a) batteries; (b) skin preparation items; (c) adhesive supplies; (d) infusion sets; (e) insulin cartridges; (f) durable and disposable devices to assist in the injection of insulin; and (g) other required disposable supplies;
   (3) insulin infusion devices;
   (4) podiatric appliances for prevention of complications associated with diabetes;
   (5) blood glucose monitors, including blood glucose monitors for the legally blind;
   (6) lancets and lancet devices;
   (7) test strips for glucose monitors;
   (8) insulin and insulin analogs;
   (9) injection aids, including devices used to assist with insulin injection and needleless systems;
   (10) glucagon emergency kits;
   (11) syringes;
   (12) oral agents for controlling blood sugar;

(13) biohazard disposal containers;
(14) repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump; and
(15) prescription drugs (bears the legend "Caution: Federal law prohibits dispensing without a prescription") and medications available without a prescription for controlling the blood sugar level.

Coverage shall also include diabetes self-management training prescribed by a Physician, including Medically Necessary medical nutrition therapy relating to diet, caloric intake and diabetes management (excluding programs whose only purpose is weight reduction) only if that therapy is provided by a licensed health care professional with specialized training in diabetes management, including a licensed registered dietician or a licensed certified nutritionist, and that is limited to the following:

(1) visits upon the diagnosis of diabetes;
(2) medically necessary changes in a Covered Person's self-management based on a Physician's diagnosis representing a significant change in the Covered Person's symptoms or condition; and;
(3) visits for medically necessary re-education or refresher training.

Coverage shall also be provided for: (1) office visits and consultations with Physicians and practitioners for monitoring and treatment of diabetes, including office visits and consultations with appropriate specialists; (2) immunizations required by Insurance Code Article 21.53F, Coverage for Childhood Immunizations; (3) immunizations for influenza and pneumococcus; (4) inpatient services, and Physician and practitioner services when the insured is confined to a Hospital, rehabilitation facility, or a skilled nursing facility; and (5) inpatient and outpatient laboratory and diagnostic imaging services.

(e) Item 6 regarding Prostate screening tests, is deleted in its entirety and replaced with the following:

Prostate screening tests: Coverage shall include expenses incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer for male Covered Persons as follows: (1) a physical examination for the detection of prostate cancer; and (2) a prostate-specific antigen test used for the detection of prostate cancer for each male Covered Person who is:

(A) at least 50 years of age and asymptomatic; or
(B) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

(f) Item 7, regarding Child Preventive and Primary Care Services, is amended to provide that child immunizations for covered children through age 6 are not subject to any deductible, co-payment or coinsurance provisions.

(g) Item 8 regarding Breast Reconstruction due to Mastectomy, is deleted in its entirety and replaced with the following:

Breast Reconstruction due to Mastectomy: Benefits will be provided for Covered Expenses for the following:

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

Coverage for a Medically Necessary mastectomy will include inpatient care for a Covered Person for a minimum of: (I) 48 hours following a mastectomy; or (ii) 24 hours following a lymph node dissection for the treatment of breast cancer, unless the Covered Person and their Physician agree that a shorter period of time is appropriate.

Benefits payable for breast reconstruction due to mastectomy shall be payable without any dollar limitations other than the Participation Certificate lifetime maximum.

10. Section 2, Description of Coverages, is amended to provide the following Covered Services:

(a) **Outpatient Prescription Drugs**: If coverage for outpatient prescription drugs is provided in Schedule of Benefits Table 3, such coverage will include FDA approved prescription contraceptives, or devices and outpatient contraceptive services. For purposes here, "outpatient contraceptive service" means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy. A prescription drug that was covered for a medical condition or mental illness shall be available to the Covered Person at the contracted benefit level until the Covered Person's renewal date, regardless of whether the prescribed drug has been removed from the Participation Certificate's drug formulary.

(b) **Telehealth Services and Telemedicine Medical Services:** Coverage shall include telehealth services and telemedicine medical **services, as defined below:**
"Telehealth service" means a health service, other than a telemedicine medical service, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

(a) compressed digital interactive video, audio, or data transmission;

(b) clinical data transmission using computer imaging by way of still-image capture and store and forward; and
(c) other technology that facilitates access to health care services or medical specialty expertise.

"Telemedicine medical service" means a health care service initiated by a Physician provided by a health professional acting under Physician delegation and supervision, for purposes of patient assessment by a health professional, diagnosis or consultation by a Physician, treatment, or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

(a) compressed digital interactive video, audio, or data transmission;
(b) clinical data transmission using computer imaging by way of still-image capture and store and forward; and
(c) other technology that facilitates access to health care services or medical specialty expertise.

(c) **Osteoporosis:** Coverage shall include expenses incurred for bone mass measurement for the detection of low bone mass and to determine a "qualified individual's" risk of osteoporosis and fractures associated with osteoporosis. As used here, a "qualified individual" means:
(a) a postmenopausal woman who is not receiving estrogen replacement therapy;
(b) an individual with:
  (1) vertebral abnormalities;
  (2) primary hyperparathyroidism; or
  (3) a history of bone fractures; or
(c) an individual who is:
  (1) receiving long-term glucocorticoid therapy; or
  (2) being monitored to assess the response to or the efficacy of an approved osteoporosis drug therapy.

(d) **Cranio Facial Abnormalities of a Child:** Coverage shall include reconstructive surgery for craniofacial abnormalities for a child who: (1) is younger than 19 years of age; and (2) has maintained continuous coverage from the date of birth in accordance with laws relating to portability. As used here, "reconstructive surgery for craniofacial abnormalities" means surgery to improve the function of, or to attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

(e) **Phenylketonuria (PKU):** Coverage shall include formulas necessary for the treatment of phenylketonuria or other inheritable diseases. As used here, "other inheritable diseases" means an inherited disease that may result in mental or physical retardation or death.

(f) **Acquired Brain Injury:** Coverage shall include expenses incurred for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

For purposes here, the following definitions shall apply:

Cognitive communication therapy -- Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive rehabilitation therapy – Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Community reintegration services – Services that facilitate the continuum of care as an affected individual transitions into the community.

Neurobehavioral testing – An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

Neurobehavioral treatment -- Interventions that focus on behavior and the variables that control behavior.

Neurocognitive rehabilitation – Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive therapy -- Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback therapy -- Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

Neurophysiological testing -- An evaluation of the functions of the nervous system.

Neurophysiological treatment -- Interventions that focus on the functions of the nervous system.

Neuropsychological testing -- The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and

emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological treatment –- Interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Post-acute transition services –- Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Psychophysiological testing –- An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological treatment –- Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

(g) **Mental Illness:** To the extent that coverage for mental illness is provided, as described in Schedule of Benefits, Table 3, such coverage will be deemed to include care received in a Psychiatric Day Treatment Facility, in a Residential Treatment Center for Children and Adolescents or from a Crisis Stabilization Unit.

Benefits payable for care in a Residential Treatment Center for Children or Adolescents or a Crisis Stabilization Unit are subject to the following:

(1) the Covered Person must have a serious mental illness which substantially impairs the Covered Person's thought, perception of reality, emotional process or judgment, or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a Hospital if such care and treatment were not available through a Crisis Stabilization Unit or Residential Treatment Center for Children or Adolescents; and
(2) the services rendered must be based on an Individual Treatment Plan; and
(3) providers of services must be licensed or operated by the appropriate state agency or board to provide those services.

As used above, **"Crisis Stabilization Unit**" means a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

"**Individual Treatment Plan**" means a treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

"**Psychiatric Day Treatment Facility**" means a mental health facility accredited by the Program for Psychiatric Facilities, or its successor, of the Joint Commission on Accreditation of Hospitals. Such facility must provide treatment for individuals suffering from acute mental and nervous disorders in a structured psychiatric program utilizing individual treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program. The facility must be clinically supervised by a Doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

"Residential Treatment Center for Children and Adolescents" means a child-care institution that provides residential care and treatment of emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

Two days of treatment in a Psychiatric Day Treatment Facility, Residential Treatment Center for Children or Adolescents, or Crisis Stabilization Unit shall be equal to one day of treatment in a Hospital or inpatient program.

(h) **Serious Mental Illness:** Coverage shall include treatment of "serious mental illness," subject to the following Calendar Year limits:
(a) 45 days of inpatient treatment; and
(b) 60 visits for outpatient treatment, including group and individual outpatient treatment.

As used here, "serious mental illness" means:
(1) schizophrenia;
(2) paranoid and other psychotic disorders;
(3) bipolar disorders (hypomaniac, manic, depressive, and mixed);
(4) major depressive disorders (single episode or recurrent);
(5) schizo-affective disorders (bipolar or depressive);
(6) pervasive developmental disorder;
(7) obsessive-compulsive disorders; and
(8) depression in childhood and adolescence.

Outpatient visits that relate to medication management will not count against the maximum number of outpatient visits allowed in a Calendar Year.

(i) **Hearing Screening Tests:** Coverage shall include expenses incurred for screening tests for hearing loss from birth through the date the child is 30 days old, including any necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. (This covered charge is not subject to any deductible, but is subject to payment of any applicable coinsurance).

11. Section 8, General Participation Certificate Exclusions, is amended as follows:

(a) Any exclusion pertaining to temporomandibular joint (TMJ) dysfunction is deleted to the extent that coverage shall be provided for diagnostic and surgical treatment of TMJ and craniomandibular joint disorder.

(b) Any exclusion pertaining to drugs labeled "Caution – limited by federal law to investigational use" or experimental drugs will not apply to any drug prescribed to treat a Covered Person for a covered chronic, disabling, or life-threatening illness if the drug: (1) has been approved by the Food and Drug Administration for at least one indication; and (2) is recognized for treatment of the indication for which the drug is prescribed in: (a) a prescription drug compendium approved by the commissioner; or (b) substantially accepted peer-reviewed medial literature. Coverage shall include any Medically Necessary services associated with the administration of the drug.

(c) Exclusion 13 is amended to provide that it does not apply to institutions that are tax supported.

(d) Exclusion 15 is amended to provide that it does not apply to reconstruction for craniofacial abnormalities in children.

(e) The reference to self-inflicted injuries in Exclusion 22 is amended to provide that it applies only to intentional self-inflicted injuries.

(f) Exclusion 23 is deleted in its entirety and replaced with the following:

23. Loss due to war, declared or undeclared; service in the armed forces of any country or international authority; active participation in a riot; active participation in a civil commotion; or active participation in acts of terrorism.

12. Section 11, Coordination of Benefits, is amended to include the following definition:
Plan means any of the following which provide benefits or services for, or on account of, medical care or treatment:
1. Group insurance and group subscriber contracts; uninsured arrangements of group and group-type coverage; group or group-type coverage through HMOs and other prepayment group practice and individual practice plans; group-type contracts which are contracts that are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group; the amount by which group or group-type hospital indemnity benefits exceeds $100 per day; and the medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault"-type contracts; and
2. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to states for medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess of those of any private program or other non-governmental program.

13. The When an Eligible Participant's Coverage Ends provision, found in Section 12, Eligibility Requirements and Period of Coverage, is amended to provide that premium will be pro-rated if it is later determined that the enrollment form contained inaccurate or misleading information that is material to the risk assumed by the Insurer.

14. The Coverage of Newborn Infants and Adopted Children provision, found in Section 13, is amended to provide benefits to the newborn child of an Eligible Dependent daughter of an Eligible Participant. In addition, item 1 is deleted in its entirety and replaced with the following:

1. Notice of the birth, notice of placement of a child for adoption, or notice that the Eligible Participant is a party in a suit in which adoption is sought must be provided to the Insurer or to the Administrator within 31 days from the date of birth, the date that the Eligible Participant becomes a party in a suit in which adoption is sought or date of placement; and

In addition, this provision is amended to clarify that a child that becomes insured due to a court order will be covered for the first 31 days on the same basis as newborns and adopted children.

15. The Time for Payment of Claim provision, found in Section 14, Claim Provisions, is amended to provide that benefits payable under the Participation Certificate, other than benefits for loss of time, shall be paid not later than 60 days after receipt of written proof of loss.

16. The Payment of Claims provision found in Section 14, Claim 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 Participation Certificate 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 Participation Certificate 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 Participation Certificate, 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 Participation Certificate. Any benefits payable for expenses not paid by such Department will be paid as provided in the Participation Certificate.

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

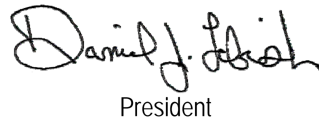
court of competent jurisdiction in this or any other state names such person the possessory or managing conservator of the child.
To be entitled to receive benefits, a possessory or managing conservator of a child must submit to the Insurer with the claim form, written notice that such person is the 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 Participation Certificate.

17. Section 15, General Provisions, is amended to contain the following provision, and such provision is applicable if coverage is shown to be available through preferred providers in Schedule of Benefits, Table 2.

    Notice of Termination of PPO arrangement with preferred providers. If the Insurer terminates a PPO arrangement with a preferred provider, proper notice will be sent to Eligible Participants advising of the Insurer's termination and will make available a current listing of preferred providers. The Insurer's termination of a preferred provider, except for reasons of medical competence or professional behavior, shall not release the Physician from the generally recognized obligation to treat the Covered Person and to cooperate in arranging for appropriate referrals. Nor does it release the Insurer from the obligation to reimburse the Covered Person at the preferred provider rate if, at the time of the Insurer's termination of the preferred provider, the Covered Person has special circumstances such as a disability, acute condition, or life-threatening illness or is past the 24th week of pregnancy and is receiving treatment in accordance with the dictates of medical prudence. ("Special circumstances" means a condition such that the treating Physician reasonably believes that discontinuing care by the treating Physician could cause harm to the patient.) Special circumstances will be identified by the treating Physician, who must request that the Covered Person be permitted to continue treatment under the Physician's care and agree not to seek payment from the patient of any amounts for which the Covered Person would not be responsible if the Physician were still a preferred provider. The continuity of coverage under this provision will not be extended beyond 90 days of the effective date of the Insurer's termination of the provider (beyond 9 months in the case of a Covered Person who has been diagnosed with a terminal illness). However, if the Covered Person, at the time of the preferred provider's termination, is past the 24th week of pregnancy, the continuity will be extended through delivery of the child, immediate post-partum care, and the follow-up checkups within the first 6 weeks of delivery.

18. The Subrogation provision, found in Section 15, General Provisions, is amended to provide that the Insurer shall not be entitled to a refund of all benefits the Insurer has paid until the Covered Person has been made whole.

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



President

HM LIFE INSURANCE COMPANY

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222
1-800-328-5433
Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

Endorsement to Certificate

Providing Coverage for Rehabilitative and Habilitative Therapies

for Children with Developmental Delays

State of Texas

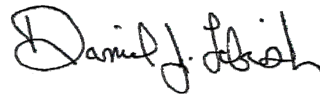
This Endorsement is made part of the Participation Certificate/certificate to which it is attached as of the effective date of such Certificate.

By attachment of this Endorsement, and in consideration of the additional premium applicable thereto, it is understood and agreed that the insurance under the Participation Certificate/certificate is amended to provide coverage for rehabilitative and habilitative therapies for children with developmental delays on the same basis as any other sickness under the Participation Certificate.

As used here, "rehabilitative and habilitative therapies" include:
(1) occupational therapy evaluations and services;
(2) physical therapy evaluations and services;
(3) speech therapy evaluations and services; and
(4) dietary or nutritional evaluations.

This benefit is not subject to any annual or lifetime benefit maximums.

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



President

HM LIFE INSURANCE COMPANY

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222
1-800-328-5433
Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

Endorsement to Certificate

Providing Coverage for Speech and Hearing Disorders

State of Texas

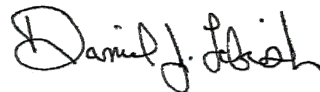
This Endorsement is made part of the Certificate to which it is attached as of the effective date of such Certificate.

By attachment of this Endorsement, and in consideration of the additional premium applicable thereto, it is understood and agreed that the insurance under the Certificate is amended to provide coverage for hospital or medical treatment for the loss or impairment of speech or hearing on the same basis as any other sickness under the Participation Certificate.

"Loss or impairment of speech or hearing" shall include communicative disorders generally treated by a speech pathologist, audiologist or

speech/language pathologist licensed by the State or certified by the American Speech-Language and Hearing Association.

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



President

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120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222
1-800-328-5433
Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

Endorsement to Participation Certificate/Certificate

Providing Coverage for In Vitro Fertilization

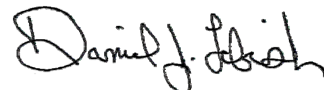
State of Texas

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

By attachment of this Endorsement, and in consideration of the additional premium applicable thereto, it is understood and agreed that the insurance under the Certificate is amended to provide coverage for in vitro fertilization when:

1. the patient is a covered person; and
2. the patient's occytes are fertilized with the sperm of the patient's spouse; and
3. the patient and the patient's spouse have a history of infertility of at least five (5) continuous years duration; or
4. the infertility is associated with one or more of the following medical conditions:
   (a) Endometriosis;
   (b) Exposure in utero to Diethylstilbestrol, commonly known as DES;
   (c) Blockage of or surgical removal of one or both fallopian tubes (lateral or bilateral salpingectomy); or
   (d) Oligospermia;
5. the in vitro fertilization procedures are performed at a medical facility that conforms to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization; and
6. the patient has been unable to obtain successful pregnancy through any less costly applicable infertility treatment for which coverage is available under the Participation Certificate.

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



President

TEXAS NOTICE

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call HM Life Insurance Company toll-free telephone number for information or to make a complaint at:

1-800-328-5433

You may write to HM Life Insurance Company at

Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222-3099

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas
Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX #(512) 475-1771

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.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de HM Life Insurance Company para informacion o para someter una queja al:

1-800-328-5433

Usted puede escribir a HM Life Insurance Company at

Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222-3099

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departmento de
Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
FAX #(512) 475-1771

DISPUTAL SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVIOS A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.