HM LIFE INSURANCE COMPANY

120 Fifth Avenue, Fifth Avenue Place
Pittsburgh, Pennsylvania 15222
1-800-328-5433

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

USAID Plan B

For U.S. based activities; medical screening <u>is required</u> prior to enrollment and departure

CERTIFICATE OF COVERAGE

BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE

POLICY NO. HM-2111-10 ("the Policy")

Participating Organization or Institution:	US Agency for International Development
Participating Organization's or Institution's Effective Date:	November 7, 2010
Eligible Participant:	See Identification Card Issued to Participant
Coverage Start Date:	See Identification Card Issued to Participant

This Certificate refers to an Eligible Participant 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

TABLE OF CONTENTS

SECTION 1	SCHEDULE OF BENEFITS – Eligible Classes	Page 2
	SCHEDULE OF BENEFITS – TABLE 1	Page 2
	SCHEDULE OF BENEFITS – TABLE 2 Coverage A – Medical Benefits	Page 2
	SCHEDULE OF BENEFITS – TABLE 3 Coverage A – Medical Expense Benefits	Page 3
SECTION 2	DESCRIPTION OF COVERAGES – Coverage A – Medical Expenses	Page 3
SECTION 3	DESCRIPTION OF COVERAGES – Coverage B – Repatriation of Remains Benefit	Page 4
SECTION 4	DESCRIPTION OF COVERAGES – Coverage C – Medical Evacuation Benefit	Page 4
SECTION 5	PRE-EXISTING CONDITION LIMITATION	Page 5
SECTION 6	GENERAL POLICY EXCLUSIONS	Page 5
SECTION 7	DEFINITIONS	Page 6
SECTION 8	EXTENSION OF BENEFITS	Page 8
SECTION 9	EXCESS COVERAGE	Page 8
SECTION 10	ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE	Page 8
SECTION 11	CLAIM PROVISIONS	Page 8
SECTION 12	GENERAL PROVISIONS	Page 9

SECTION 1
SCHEDULE OF BENEFITS
ELIGIBLE CLASSES

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

_X_ Class I: Participant selected to attend a training or educational program which requires the use of ADS 252/253 provisions.

_X_ Class II: Foreign Service National (FSN) or Third Country National (TCN) subject to the use of USAID Policy contained in ADS 496 provisions.

All benefits and limits are stated per Covered Person

SCHEDULE OF BENEFITS
TABLE 1

	Limits Eligible Participant
COVERAGE A – MEDICAL EXPENSES	
Maximum Benefit per Injury or Sicknesses	$150,000
Copayment per Injury of Sickness	$10 per Injury or Sickness
COVERAGE B – REPATRIATION OF REMAINS	Maximum Benefit up to $7,500
COVERAGE C – MEDICAL EVACUATION	Maximum Lifetime Benefit for all Evacuations up to $10,000

SCHEDULE OF BENEFITS
TABLE 2

COVERAGE A – MEDICAL EXPENSES	Indemnity Plan Limits
Physician Office Visits	After Copayment, 100% of Reasonable Expenses
Inpatient Hospital Services	After Copayment, 100% of Reasonable Expenses
Hospital and Physician Outpatient Services	After Copayment, 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	Limits – Covered Person
Maternity Care for a Covered Pregnancy	Reasonable Expenses
Inpatient treatment of mental and nervous disorders	Reasonable Expenses for a maximum period of 30 days
Outpatient treatment of mental and nervous disorders	Reasonable Expenses up to $1,500 Maximum and with a Maximum of $75 per visit
Treatment of specified therapies, including acupuncture and Physiotherapy	Reasonable Expenses on an Inpatient basis. Reasonable Expenses up to $35 Maximum per visit subject to a Maximum of 30 visits on an Outpatient basis.
Medical treatment arising from participation in intercollegiate, interscholastic, intramural, club or professional sports	Reasonable Expenses up to $1,000 Maximum per Injury or Sickness
Vaccinations required by Participating Organization or Institution	100% of Reasonable Expenses
Repairs to teeth required due to an Injury	100% of Reasonable Expenses up to $250 Maximum per tooth per Injury
Dental Treatment (including extractions) to alleviate pain	100% of Reasonable Expenses up to $500
Repair or replacement of an existing prosthetic device	100% of Reasonable Expenses up to $500
Outpatient prescription drugs	100% of actual charge
Professional ground or air ambulance service to nearest hospital	Reasonable Expenses up to $500 per Injury or Sickness

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 stated in Coverage A – Medical Expenses of Table 1 of the Schedule of Benefits. Benefits are subject to the Deductible Amount, Co-insurance, 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 30 days after the date the insurance terminates.

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

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

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

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

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

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

   If the physician, in consultation with the mother, determines that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's office, as determined by the physician in consultation with the mother. The 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, if legally required to do so the collection of an adequate sample for hereditary and metabolic newborn screening.

D. Home Country Coverage (Conditions First Diagnosed or Treated in the Country of Assignment): Expenses incurred within the Covered Person's Home Country while insured under the Policy will be considered as Covered Medical Expenses when:
1. They are Medically Necessary and are authorized after the Covered Person has proven Sickness or Injury in the Country of Assignment; or
2. They are related to a pre-approved medical evacuation and would have been covered had the expenses been incurred in the Country of Assignment.

Payment is subject to the Limitations and Conditions on Eligibility for Benefits provision.

SECTION 3
COVERAGE B – 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, including a container suitable for transport. 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 30 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 4
COVERAGE C – 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.

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

With respect to this provision only, the following is in lieu of the Policy's Extension of Benefits provision: No benefits are payable for Covered Expenses incurred after the date the Covered Person's insurance under the Policy terminates. However, if on the date of termination the Covered Person is Hospital Confined, then coverage under this benefit provision continues until the earlier of the date the Hospital Confinement ends or the end of the 30st day after the date of termination.

The combined benefit for all necessary evacuation services is listed in Table 1 of the Schedule of Benefits.

SECTION 5
LIMITATIONS

A. Pre-Existing Condition Limitation

The Insurer does not pay benefits for loss due to a Pre-Existing Condition during the first one (1) year of coverage.

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

SECTION 6
GENERAL POLICY EXCLUSIONS

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

1. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health.
2. Expenses incurred in excess of Reasonable Expenses.
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 and to the Repatriation of Remains 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 and to the Repatriation of Remains 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. Except as by state mandate, the diagnosis or treatment of Congenital Conditions, except if legally required to do so for a newborn child of an insured individual under the Policy.
16. Treatment for TMJ dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia.
17. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
18. Diagnosis and treatment of acne and sebaceous cyst.
19. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.

20. Self-inflicted Injuries while sane or insane; suicide, or any attempt thereat while sane or insane. This exclusion does not apply to the Medical Evacuation Benefit and to the Repatriation of Remains Benefit.
21. Loss due to war, declared or undeclared; service in the armed forces of any country or international authority; riot; civil commotion; or acts of terrorism.
22. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.
23. 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.

SECTION 7
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.

Administrator means HTH Worldwide Insurance Services.

Age means the Covered Person's attained age.

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

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

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

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

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

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

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

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

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

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 Participant means a person who:
1. Is engaged in international educational activities and/or training activities; and
2. Is temporarily located outside his/her Home Country as a non-resident alien.

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.

Home Country means the Covered Person's country of domicile named on the enrollment form or the roster, as applicable.

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.

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.

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.

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 up to one (1) year 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.

SECTION 8
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 30 days after the date the insurance terminates.

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

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

SECTION 9
EXCESS COVERAGE

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

SECTION 10
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.

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.

When an Eligible Participant's Coverage Starts: Coverage for an Eligible Participant starts at 12:00:01 a.m. local home country time when their travel begins for their assignment.

Thereafter, the insurance is effective 24 hours a day, worldwide.

When an Eligible Participant's Coverage Ends: Coverage will end at 11:59:59 p.m. local home country time on the last date of insurance. A Covered Person's coverage will end without prejudice to any claim existing at the time of termination.

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.

SECTION 11
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.

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 12
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 Law: If any provision of the policy is contrary to the laws or regulations/bulletins of the jurisdiction in which it is delivered, such provision is hereby amended to conform to the laws or regulations/bulletins of that jurisdiction.

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.

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.

There will be made available to the Covered Person, a member services representative to assist the Covered Person throughout the grievance process. The Covered Person also has a right to designate an outside independent representative to assist the covered person or the Covered Person's member services representative through the grievance process.

The insurer will respond to grievances it receives within 45 business days of receipt of the grievance. The insurer will inform the Covered Person in writing of the decision regarding the covered person's grievance.

All communications regarding the grievance/appeals process will be recorded, documented and maintained for at least 3 years.

If the matter is still not resolved to the Covered Person's satisfaction, he/she may appeal any grievance decision resulting in a denial, termination, or other limitation of covered health care services by requesting 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.

There shall be three levels of appeal of a grievance decision.

Informal Internal Review: An Informal Internal Review shall consist of the Covered Person's right to discuss and appeal the insurer's grievance decision with the insurer's medical director or with the physician or health care provider designee who rendered the decision.

If an appeal is from a determination regarding urgent or emergency care, the insurer shall conclude the appeal within 24 hours of receiving notification of appeal from the covered person or his/her member service's representative. All other concurrent or prospective appeals conducted pursuant to this section shall be conducted by the insurer within 14 business days, unless the medical circumstances surrounding the case require the insurer to respond sooner.

If the Informal Internal Review is not concluded to the Covered Person's satisfaction, the insurer shall provide the Covered Person with a written explanation of the decision, which shall, at a minimum, consist of:

1. The reviewer's understanding of the grievance;
2. The reviewer's decision in clear terms;
3. The contract basis or medical rationale in enough detail for the member or member representative to understand and to respond to the insurer's position; and
4. All applicable instructions, including the telephone numbers and titles of persons to contact and time frames to appeal the decision to the next stage of appeal.

If still dissatisfied, the covered person or his/her member representative has a right to engage in a second level appeal.

Formal Internal Review: If dissatisfied with the Informal Internal Review decision, the Covered Person shall have a right to appeal before a reviewer or panel of physicians, or advanced practice registered nurses, or other health care professionals selected by the insurer.

The panel of reviewers selected by the insurer shall not have been involved in the initial grievance decision under review.

For all reviews which require medical expertise, the medical reviewer or in the case of a panel of reviewers, the panel shall consist of at least one medical reviewer who is trained or certified in the same specialty as the matter at issue.

A medical reviewer shall be a physician, or an advanced practice registered nurse or other appropriate health care provider possessing a non-restricted license to practice or provide care anywhere in the United States and have no history of disciplinary action or sanctions pending or taken against them by any governmental agency or professional regulatory body.

A medical reviewer shall be certified by a recognized specialty board in the areas appropriate to review.

All Formal Internal Reviews will be acknowledged by the insurer within 10 business days of receipt.

If the Formal Internal Appeal is from a determination regarding urgent or emergency care, the insurer shall conclude the appeal within 24 hours of receiving notification of appeal from the covered person or his/her member representative. All other concurrent or prospective appeals conducted pursuant to this section shall be conducted by the insurer within 30 business days, unless the medical circumstances surrounding the case require the

insurer to respond sooner. The time may be extended at the request of the Covered Person or his/her member services representative.

If the Formal Internal Review is not concluded to the Covered Person's satisfaction, the insurer shall provide the Covered Person with a written explanation of the decision, which shall, at a minimum, consist of:

1. The reviewer's understanding of the grievance;
2. The reviewer's decision in clear terms;
3. The contract basis or medical rationale in enough detail for the member or member representative to understand and to respond to the insurer's position; and
4. All applicable instructions, including the telephone numbers and titles of persons to contact and time frames to appeal the decision to the next stage of appeal.

If the covered person or his/her member representative is dissatisfied with the Formal Internal Review decision, he/she may pursue an external grievance.

If the insurer fails to comply with any of the deadlines for completion of a formal internal appeal, the covered person or his/her member representative shall be relieved of his/her obligations under the Formal Internal Review Process and may proceed directly to the external appeal process.

External Grievance Process: If dissatisfied with the decision rendered in a Formal Internal Review, the Covered Person may pursue an External Review before an independent review organization.

Within 30 business days from receipt of a written decision of the formal internal appeal panel, the Covered Person shall file a written request with the director for an external review along with a signed release, allowing the insurer to release medical records pertinent to the appeal.

Upon receipt of the request for an external appeal, together with the executed release form, the Director shall determine whether:

(1) The individual was or is a member of the health benefits plan;
(2) The health care service which is the subject of the appeal reasonably appears to be a service covered by the health benefits plan;
(3) The member or member representative has fully complied with the informal and formal internal appeals processes; and
(4) The member or member representative has provided all information required by the independent review organization and the Director to make the preliminary determination, including the appeal form, and a copy of any information provided by the insurer regarding its decision to deny, reduce, or terminate a covered service, and the release form required pursuant to subsection (b) of this section.

Upon completion of the preliminary review, the Director shall notify the member or member representative and insurer in writing as to whether the appeal has been accepted for processing. If the appeal is accepted by the Director, the Director shall assign the appeal to an independent review organization for full review. If the appeal is not accepted by the Director, the Director shall provide a statement of the reasons for the non-acceptance to the member or member representative and the insurer.

The staff of the independent review organization that is assigned to the appeal shall have meaningful prior experience in performing utilization review, peer review, quality of care assessment or assurance, or the hearing of appeals. Any independent review organization, its staff, and its professional and medical reviewers, shall not have any material, professional, familial, or financial affiliation with the insurer that is a party to the appeal.

The Director may waive exhaustion of the informal and formal appeals process as a prerequisite for proceeding to the external appeals process in cases of emergency or urgent care.

The insurer shall provide timely access to all its records relating to the matter under review and to all provisions of the health benefits plan or health insurance coverage, including any evidence of coverage, "member handbook", certificate of insurance or contract and health benefits plan relating to the matter.

Upon acceptance of the appeal for processing, the independent review organization shall conduct a full review to determine whether, as a result of the insurer's decision, the member was deprived of any service covered by the health benefits plan.

The full review of an appeal of a health benefits decision shall be initially conducted by at least 2 physicians licensed to practice medicine in the District of Columbia, Maryland, or Virginia. On an exceptions basis, when necessary based on the medical, surgical, or mental condition under review, the independent review organization may select medical reviewers licensed anywhere in the United States who have no history of disciplinary action or sanctions pending or taken against them by any governmental or professional regulatory body.

In reaching a determination, the independent review organization shall take into consideration all pertinent medical records, consulting physician reports, and other documents submitted by the parties, any applicable generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards and associations, any applicable clinical protocols or practice guidelines developed by the insurer, and may consult with such other professionals as appropriate and necessary.

The member or member representative and one insurer representative may request to appear in person before the independent review organization. The independent review organization shall conduct the hearing in the District of Columbia. The independent review organization's procedures for conducting a review, when the member or member representative or the insurer has requested to appear in person, shall include the following:

(1) The independent review organization shall schedule and hold a hearing as soon as possible after receiving a request from a member or member representative or from an insurer representative to appear before the independent review organization. The independent review organization shall notify the member or member representative and insurer representative, either orally or in writing, of the hearing date and

location. The independent review organization shall not unreasonably deny a request for postponement of the hearing made by the member or member representative or insurer representative.

(2) A member or member representative and an insurer representative shall have the right to the following:
   (A) To attend the independent review organization hearing;
   (B) To present his or her case to the independent review organization;
   (C) To submit supporting material both before and during the hearing;
   (D) To ask questions of any representative of the independent review organization; and
   (E) To be assisted or represented by a person of his or her choice.

When necessary, the independent review organization shall consult with a physician or advance practice registered nurse trained in the same specialty or area of practice as the type of treatment that is the subject of the grievance and appeal. All final recommendations of the independent review organization shall be approved by the medical director of the independent review organization.

The independent review organization shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case. Except as provided for in this subsection, the independent review organization shall complete its review within 30 business days, or 72 hours in the case of an expedited appeal, from the time the Director assigns the appeal to the independent review organization. An insurer shall provide all documentation to the independent review organization within 5 days of receipt of the notice of approval of the appeal by the Director, or within 24 hours of receipt of the notice of approval of the grievance, for an expedited review. If an insurer does not provide the independent review organization all documentation required by this subsection within the time frames, or obtain the necessary extensions, the independent review organization may decide the appeal without receiving the information. The independent review organization shall extend its review for a reasonable period of time as may be necessary due to circumstances beyond its or the insurer's control, but only when the delay will not result in increased medical risk to the member. In such an event, the independent review organization shall, prior to the conclusion of the initial review period, provide written notice to the member or member representative and to the insurer setting forth the status of its review and the specific reasons for the delay.

If the independent review organization determines that the member was deprived of medically necessary covered services, the independent review organization shall recommend to the Director the appropriate covered health care services the member should receive. The Director shall forward copies of the recommendation to the member or member representative and the insurer.

When necessary, the independent review organization shall refer a case for review to a consultant physician or other health care provider in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the independent review organization shall be approved by the medical director of the independent review organization.

The decision of the independent review organization shall be nonbinding on all parties and shall not affect any other legal causes of action.

This section shall not apply in cases directly involving Medicaid benefits.

Any appeal brought pursuant to this section by a member involving coverage provided pursuant to the Medicaid program shall be resolved in accordance with federal and District of Columbia laws, regulations, and procedures established for fair hearings and appeals for the Medicaid program.

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.

In the case of a reduction or a termination of services that is contrary to the recommendations of the treating physician or advance practice registered nurse, an insurer shall provide a member or member representative with 24 hours prior verbal notification, followed by a written decision as soon as practical.

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
P.O. Box 535061, Suite P6504
Pittsburgh, PA 15253-5061
1-800-328-5433

If the Covered Person is dissatisfied with the insurer's resolution, the Covered Person has a right to contact the Director of Insurance. For issues concerning medical necessity of treatment contact:

Department of Health
Attn: Charlita Brown
825 North Capital Street, Room 4119
Washington, D.C. 20002

For all other issues contact:

The Commissioner of Insurance
810 First Street, Room 701
Washington, D.C 20002

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.