



# Starr Indemnity & Liability Company

Dallas, Texas  
Administrative Office: 399 Park Avenue, 8<sup>th</sup> Floor, New York NY 10022

## CERTIFICATE OF INSURANCE

Group Policy Number: NCE-100001 ("the policy"), has been issued to The National Congress of Employers which we refer to as "the Policyholder". We will refer to Starr Indemnity & Liability Company as "We", "us", or "our".

The policy will be administered on our behalf by "the Administrator," International Benefits Administrators.

The policy was delivered in Washington D.C. and will be governed by the laws thereof and, to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any of its amendments.

The Certificate of Insurance is evidence of the Insured's insurance under the policy and of its benefits. Everything contained in this Certificate of Insurance is subject to the provisions, definitions, and exceptions in the policy. The policy is on file with the "the Policyholder" and may be examined at any reasonable time. Only one of our executive officers can authorize a change to the policy.

This Certificate replaces all Certificates and Certificate Riders, if any, previously issued to the Insured under the policy.

Signed for STARR INDEMNITY & LIABILITY COMPANY BY:

Honora M. Keane, General Counsel

Charles H. Dangelo, President

### PLEASE READ THIS CERTIFICATE CAREFULLY

**THIS LIMITED HEALTH BENEFIT PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS CERTIFICATE AND CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE COVERED PERSON AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS.**

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## GENERAL DEFINITIONS

"Accident" means a sudden, unforeseeable event, independent of Sickness that causes Injury to one or more Covered Persons.

"Ancillary Services" means standard medical procedures that are reasonably necessary for the diagnosis and treatment of a patient.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985.

"Complications of pregnancy" means: 1) Conditions (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, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and 2) Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

"Coverage Year" means the period of time, as stated on the Schedule of Benefits, from the date of Injury or first treatment of Sickness within which benefits will be paid.

"Covered Person" means any eligible person for whom coverage is in effect under the policy.

"Deductible" means the amount of eligible Medical Expenses which must be satisfied for each covered loss before benefits are payable under the policy.

"Dependents" means: a) the Insured's lawful spouse, and b) the Insured's unmarried children who are less than age 19. An unmarried child who is less than age 23 may also be included if the child is enrolled full-time in an accredited school or college. All references to the term "spouse" include "domestic partner". The term "domestic partner" means a person with whom the Insured maintains a committed relationship characterized by mutual caring and the sharing of a mutual residence and who has registered. Each partner must: 1) be at least 18 years old and competent to contract; 2) be the sole domestic partner of the other person; and 3) not be married.

Dependent children may include stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures and children for whom coverage has been court-ordered. Dependent children (other than those for whom coverage has been court-ordered) must: 1) have their principal residence with the Insured; and 2) chiefly rely on the Insured for support and maintenance.

"Doctor" means any duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to perform the service for which claim is made.

"Emergency Services" means: 1) Health care services furnished in the emergency department of a hospital for the treatment of a Medical Emergency; 2) Ancillary Services routinely available to the emergency department of a hospital for the treatment of a Medical emergency; and 3) Emergency medical services transportation.

"Hospital" means an institution operated by law for the care and treatment of injured or sick persons; has organized facilities for diagnosis and surgery or has a contract with another hospital for these services; and has 24-hour nursing service. Hospital excludes any institution that is primarily a rest home, nursing home, convalescent home, a home for the aged, an alcoholism or drug addiction treatment facility, or a facility for treatment of mental disorders.

"Injury" means accidental bodily injury of a Covered Person caused by an Accident; and results in covered loss directly and independently of all other causes. All injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries, will be considered one Injury.

"Inpatient" means a person who incurs Medical Expenses for at least one day's room and board from a Hospital.

"Insured" means an eligible person for whom coverage is in effect under the policy.

"Intoxicant or Intoxicated" means blood alcohol level which equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Injury occurred.

"Maximum Benefit " means the total benefits payable under an applicable benefit provision.

"Medical Emergency" means the sudden onset or sudden worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in: 1) Placing the patient's health in serious jeopardy; 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

"Medical Expense" means expenses incurred for Medically Necessary services and supplies. Not included are amounts in excess of Usual and Customary Charges.

"Medically Necessary" means the care, service or supply is prescribed by a Doctor for the diagnosis or treatment of an Injury or Sickness; and appropriate, according to conventional medical practice for the injury or Sickness in the locality in which care, service or supply is given. The fact that a Doctor may prescribe, authorize, or direct a service does not, of itself, make it Medically Necessary or covered by the policy.

"Member" means a person who has joined an association, is required to pay on a regular basis a specific amount of annual dues that are predetermined by the association, and has paid annual dues in good standing.

"Occurrence" means each separate Accident or Sickness for which a Covered Person incurs covered Medical Expenses.

"Outpatient" means a person who incurs Medical Expenses at Doctors offices, freestanding clinics, or at Hospitals when not admitted as an Inpatient.

"Pre-existing Condition" means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received from a physician within a 6 month period preceding the effective date of coverage of the Covered Person.

"Policyholder" means the legal entity in whose name this Policy is issued as shown on the Policy cover.

"Resource Based Relative Value Schedule (RBRVS)" means a scale of national uniform relative value for all physicians' services. The method reflected in this scale determines provider reimbursement, taking into account, when assigning a weighted value to medical procedures or services, all resources that physicians use in providing care to patients, including physical or procedural, educational, mental (cognitive) and financial resources.

"Sickness" means illness or disease for which a Medical Expense is incurred while coverage is in force under the policy for the Covered Person. All related conditions and recurring symptoms of Sickness will be considered one Sickness. Sickness also includes Complications of Pregnancy.

"Totally Disabled" means the Covered Person is receiving medical treatment and is unable to perform all the substantial and material duties of his work. In respect to a dependent or unemployed spouse, Totally Disabled shall mean an Injury or Sickness that prevents the Covered Person from doing those activities that are normal for a person in good health of the same age and sex.

"Usual and Customary" means an amount that is both charged by a provider for a given service to the majority of his patients, and charged by the majority of providers within a community for the same service.

"Waiting Period" means the period of time during which benefits are not paid.

## **INDIVIDUAL INSURING PROVISIONS**

### **Eligibility:**

**Insured:** Each person, as described on the Schedule of Benefits, who is eligible for coverage under the policy as an Insured.

**Eligible Dependents:** Coverage under the policy may also be extended to include:

- a.) the Insured's lawful spouse; and
- b.) the Insured's unmarried children who are less than age 19. An unmarried child who is less than age 23 may also be included if the child is enrolled full-time in an accredited school or college.

Dependent children may include stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures and children for whom coverage has been court-ordered.

Dependent children (other than those for whom coverage has been court-ordered) must:

- a.) have their principal residence with the Insured; and
- b.) chiefly rely on the Insured for support and maintenance.

**Newborn Child Coverage:** A child of the Insured born while the Policy is in force is covered for Injury and Sickness (including necessary care and treatment of congenital defects, birth abnormality and premature birth), as well as routine newborn care for the first 31 days. The child is covered from the moment of birth until the 31st day of age. A notice of birth, together with the additional premium, must be submitted to us within 31 days of the birth in order to continue coverage for Injury or Sickness beyond the initial 31-day period.

**Adopted Child Coverage:** A minor child who comes under the charge, care and control of the Insured while the policy is in force is covered for injury or Sickness, provided the Insured files a petition to adopt. The coverage of such child will be the same as provided for other members of the Insured's family. Such child shall be covered from the date of placement in the Insured's home if the insured applies for coverage and pays any required premium within 31 days after the date of placement. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. Such child's coverage will not be subject to any preexisting conditions limitation provided by this policy. Coverage for such minor child will continue unless the petition for adoption is dismissed or denied.

**Effective Date:**

Insured - Contributory: Individual insurance will become effective on the latest of:

- a.) the Policyholder's effective date, if the person is eligible, and application and premium have been received on or before that date; or
- b.) the date the person enrolls and application and premium are received within 31 days after the date he becomes eligible; or
- c.) as provided on the Schedule of Benefits.

Dependents: Dependent insurance will become effective on the latest of:

- a.) the Insured's effective date, if the dependent is eligible as of the Insured's effective date and the Insured applies and pays premium for the dependent on or before that date; or
- b.) the date the Insured enrolls his dependent, if the dependent becomes eligible after the Insured's effective date, and application and premium are received within 31 days after the dependent becomes eligible; or
- c.) as provided on the Schedule of Benefits.

An eligible person may be enrolled only within 31 days after becoming eligible .

In no case will coverage for eligible dependents take effect before the Insured's. No dependent will be covered unless application has been made and the correct premium has been paid.

**Termination:**

Insured: Coverage for an Insured will end on the earliest of:

- a.) the date the Insured is no longer eligible unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid; or
- b.) any premium due date, if full payment for the Insured's coverage is not made within 31 days following the premium due date (the Grace Period); or
- c.) the date the policy terminates; or
- d.) the date the Insured enters an armed service on full-time active duty. Premium shall be returned a pro-rata basis if we are notified in writing; or
- e.) the date the Insured becomes eligible for an employer-sponsored group medical benefit program, other than the Policy, regardless of whether or not the Insured participates in such program; or
- f.) the date the insured provides the Policyholder or us with written notice that he wants his coverage terminated.

Dependents – Coverage for dependents will end on the earliest of:

- a.) the Insured's termination date; or
- b.) the date the dependent is no longer eligible unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid.

Coverage will continue for any child who reaches the age limit and is both:

- a.) totally incapable of self-sustaining employment due to physical or mental handicap; and
- b.) chiefly dependent on the Insured for support and maintenance.

The Insured must give us proof of the child's incapacity and dependency within 31 days of the child reaching the age limit. We may require proof again from time to time but not more often than once a year after the 2 years that follow the child reaching the age limit.

In no case will coverage end later than the Insured's.

Termination will not affect a claim for benefits for covered charges that were incurred while the Insured was covered under the policy.

## **DESCRIPTION OF BENEFITS**

### **Per Coverage Year Medical Expense Benefit – Inpatient and Outpatient**

We will pay the applicable benefit percentage for the covered expenses described below, up to the applicable coverage year maximum. Benefits will be paid, after satisfaction of any applicable deductible or co-pay amount and subject to any applicable benefit limitation, for covered expenses that are incurred while the Covered Person's coverage is in force. The Covered Person must be under a Doctor's care, and the treatment must be Medically Necessary, for covered Injury or Sickness. Deductible amounts and benefit percentages, maximums, and limitations are indicated on the Schedule of Benefits.

Covered expenses include: Hospital room and board charges; Inpatient surgery, surgeons' and anesthesiologists' fees; charges for other Hospital services (which include ancillary Hospital charges for pharmacy, medical or surgical supplies and devices, diagnostic laboratory and X-ray procedures, and operating and recovery room); Outpatient Doctors' office visits fees; Outpatient Doctor's office visits include habilitative services for children if any Covered Person under the age of 21 years incurs charges for habilitative services. Benefits will not be provided for habilitative services actually delivered through early intervention or school services. "Habilitative services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function; Outpatient surgery, surgeons' and anesthesiologists' fees; charges for Outpatient diagnostic laboratory and X-ray procedures; charges for the 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 Doctor legally authorized to prescribe such item, charges for routine patient care costs of items, drugs, and services furnished to a Covered Person in connection with participation in an approved clinical trial. We will not pay for costs of items, services, or drugs that are customarily provided by the sponsors of an approved clinical trial, and charges for visits to an emergency room including coverage for a voluntary HIV screening test performed on a Covered Person while the Covered Person is receiving emergency medical services, other than HIV screening, at a hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the medical emergency which caused the Covered Person to seek emergency services. Fees for Inpatient Doctors' visits and private duty nursing are not included as covered expenses. Charges incurred by a Covered Person for covered expenses are limited to Usual and Customary unless indicated otherwise on the Schedule of Benefits.

Supplemental Inpatient Hospital Benefits are payable only after the Base Inpatient Benefit has been exhausted each coverage year. Once Supplemental Inpatient Benefits become payable, we will pay the applicable benefit percentage, indicated on the Schedule of Benefits for only the following covered expenses: Hospital room and board charges, Inpatient surgeons' fees, and Inpatient anesthesiologists' fees. Other Hospital services are not covered under Supplemental Inpatient Benefits. Covered expenses will be limited to the Usual and Customary charge incurred by the Covered Person. The Covered Person must continue to be under the care of a Doctor and the treatment must be Medically Necessary for covered Injury or Sickness. Supplemental inpatient Hospital Benefits will be paid up to the applicable maximum shown on the Schedule of Benefits.

Additional Definitions – Whenever used in this benefit:

"Approved clinical trial" means:

- a. A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
  - (i) The National Institutes of Health;
  - (ii) The Centers for Disease Control and Prevention;
  - (iii) The Agency for Health Care Research and Quality;
  - (iv) The Centers for Medicare and Medicaid Services;
  - (v) A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS; or
  - (vi) The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;
- b. A study or investigation approved by the Food and Drug Administration ("FDA"), including those conducted under an investigational new drug or device application reviewed by the FDA; or
- c. An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

"Co-pay" means a specified amount that a Covered Person is responsible for paying, each time the covered expense is incurred, before benefits are payable under the policy. When a covered expense is subject to a co-pay, a deductible will not be applied to that same expense.

"Coverage year" means a consecutive 12-month period described on the Schedule of Benefits.

"Deductible" means the amount of covered expenses that must be paid by a Covered Person before benefits are payable under the policy. This amount applies separately to each Covered Person and must be satisfied each coverage year; except if, in any one coverage year, there are 3 or more members of the Insured's family covered under the policy, then a family deductible will apply. The family deductible is cumulative. This means that all covered family members can contribute to the family deductible, however, no one Covered Person can contribute more than the per person deductible amount. Once the family deductible is satisfied, no deductible amount will be required for any other covered family member during that same coverage year.

## **MENTAL HEALTH BENEFITS**

### **Inpatient Benefits**

For Covered Persons confined as an Inpatient to a licensed mental health facility due to Mental Illness we will pay benefits the same as any other Sickness, subject to the Mental Health Inpatient Maximum Benefit listed in the Schedule of Benefits which applies per Coverage Year per Certificate of Insurance.

### **Outpatient Benefits**

For Covered Persons seeking treatment for Mental Illness on an Outpatient basis at a licensed mental health facility, we will pay benefits the same as any other Sickness, subject to the Mental Health Outpatient Maximum Benefit listed in the Schedule of Benefits which applies per Coverage Year per Certificate of Insurance.

***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.

We will not pay any benefit for stays in a half-way house or other place that is not a licensed facility offering treatment for Mental Illness.

## **ALCOHOLISM AND DRUG DEPENDENCY BENEFIT**

### **Detoxification Benefits**

Benefits for the detoxification process where a Covered Person who is intoxicated by or dependent on drugs or alcohol or both is assisted through the period of time necessary to eliminate the intoxicating agent from the body, while keeping the physiological risk to the patient at a minimum, are subject to the Detoxification Maximum Benefit shown in the Schedule of Benefits.

### **Inpatient Benefits**

For Covered Persons confined as an Inpatient to a licensed alcoholism, substance abuse or chemical dependence treatment health facility due to alcoholism or drug dependency we will pay benefits the same as any other Sickness, subject to the Alcoholism and Drug Dependency Inpatient Maximum Benefit listed in the Schedule of Benefits which applies per Coverage Year per Certificate of Insurance.

### **Outpatient Benefits**

For Covered Persons seeking treatment for Alcoholism and Drug Dependency on an Outpatient basis at a licensed Outpatient treatment facility, we will pay the Alcoholism and Drug Dependency Outpatient Benefit shown in the Schedule of Benefits, which applies per treatment, subject to the Alcoholism and Drug Dependency Outpatient Maximum Benefit listed in the Schedule of Benefits which applies per Coverage Year per Certificate of Insurance.

## **WELLNESS VISIT BENEFIT**

Upon receipt of due proof that a Covered Person incurred expenses for a Wellness Visit, we will pay a Wellness Visit Benefit up to the maximum as shown in the Schedule of Benefits.

Additional Definitions – Whenever used in this benefit:

"Wellness Visit means an office visit for routine examinations or other preventative testing, including a baseline mammogram, a screening mammogram, cervical cytologic screening, diagnostic radiology/imaging, colorectal cancer screening, prostate cancer screening, and physical examination.

"Baseline mammogram" means a screening mammogram that is used as a comparison for future examinations;

"Screening mammogram" means a low dose x-ray used to visualize the internal structure of the breast; and

"Cytologic screening" means a pap test to detect cervical cancer through the simple microscopic examination of cells scraped from the surface of the cervix.

## LIMITATIONS AND EXCLUSIONS

No benefits will be paid for loss caused by or resulting from

- Normal pregnancy or childbirth, except for Complications of pregnancy;
- Nervous disorders, or substance abuse treatment, except as required by law;
- Intentionally self-inflicted injuries or sickness, suicide or any attempt thereof while sane or insane;
- Declared or undeclared war or any act thereof;
- Participation in a riot or insurrection;
- Acts of terrorism, unless committed by individuals or groups will not be excluded from coverage unless the Covered Person who suffered the loss committed the act of terrorism;
- Serving on full-time active duty in the Armed Forces of any country or international authority;
- The Covered Person's participation, commission of or attempt to commit a felony or criminal offense or to which a contributing cause was the Insured's being engaged in an illegal occupation;
- Flying other than as a fare paying passenger, as a pilot or crew member of any aircraft or travel or flight, including boarding or alighting, in any vehicle or device while being used for any test or experimental purposes or while being operated by, for or under the direction of any military authority other than the Military Airlift Command (MAC) of the United States or similar air transport service of any other country;
- Work-related Injury or Sickness, whether or not benefits are payable under any state or federal Workers' Compensation, employer's liability or occupational disease law or similar law;
- With respect to Accidental Death benefits, Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily Injury or accidental food poisoning.

In addition to the above exclusions, no benefits will be paid for:

- Routine eye examinations or fitting of glasses or contact lenses unless such coverage is provided for under the Policy;
- Hearing examinations, or hearing aids, unless provided for under the policy;
- Treatment in a Hospital or facility owned or run by the United States Government, unless a charge is made for such services in the absence of insurance; or in a Hospital that does not unconditionally require payment;
- Dental exams, care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person's coverage is in force, and rendered within 6 months of the Accident;
- Expenses used to meet any deductible, or in excess of the percentages payable, or in excess of those expenses considered Usual and Customary;
- Services provided by a member of the Covered Person's immediate family;
- Expenses incurred to the extent that they are paid or payable under any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited).
- Rest care or rehabilitative care and treatment, custodial care, and transportation;

Cosmetic surgery or care, or treatment solely for cosmetic purposes, or complication therefrom. This exclusion does not apply to:

a. Cosmetic surgery resulting from an accident, if initial treatment of the Covered Person is begun within 12 months of the date of the Accident;

b. Reconstruction incidental to or following surgery resulting from a covered Accident or Sickness or from trauma, infection or other diseases of the involved part;

c. Correction of a congenital disease or defect or anomaly that results in a functional defect of a covered Dependent child;

d. With respect to a mastectomy:

(1) All stages of reconstruction of the breast on which the mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Treatment of physical complications for all stages of the mastectomy, including lymphedema;

Immunization shots and routine examinations such as routine physical examinations or pre-marital examinations, except as required by law;

Examinations needed for employment, obtaining insurance, team sports, travel, school or camp;

Routine newborn care, including routine nursery charges, except as required benefits under state mandates;

Voluntary abortion, unless

a. The life of Covered Person or his spouse would be endangered if the fetus were carried to term; or

b. Medical complications have arisen from an abortion;

Sex change procedures;

Experimental health care services unless such services are:

a. prescribed or recommended as Appropriate Treatment by the Covered Person's Doctor; and

b. approved, on a basis other than limited or experimental, by the American Medical Association or the appropriate medical specialty society for such treatment;

Diagnosis and treatment of infertility in connection with the reversal of elective sterilizations;

Diagnosis and treatment of infertility in connection with: in vitro fertilization, gameteintrafallopian tube transfers or zygote intrafallopian tube transfers; cloning; or medical or surgical services deemed to be experimental;

Treatment of exogenous obesity, gastric bypass surgery or weight control;

Air ambulance service;

Confinement, or services or treatment received on Friday and/or Saturday in the case of a non-emergency Hospital admission, unless a surgical procedure is performed within 24 hours of admission;

For the diagnosis of, or any symptom or medical problem, which initiated any investigation leading to a diagnosis of a covered condition, when the condition commenced prior to the Effective Date;

For a Loss caused or contributed to by the use of voluntarily self-administered drugs, poisonous or chemical substance other than as prescribed and administered by or in accordance with a Doctor;

Non-therapeutic release of radiation;

For a Loss caused by or contributed to by participation in a hazardous activity, including but not limited to skydiving, land or water racing, bungee jumping, scuba diving, amateur or interscholastic athletics, sports competition or events, hang gliding, ballooning, parasailing, mountain climbing or hunting; or

For congenital defects or conditions.

Medical or healthcare treatment, services, or supplies which:

- Are not Medically Necessary; or
- Are not prescribed by a licensed Doctor as necessary to treat sickness, illness or injuries including Mental Illness; or
- Are experimental or investigational in nature, except as required by law; or
- Are received without charge or legal obligation to pay; or
- Are rendered or supplied to the Named Insured outside the United States, its possessions or the countries of Canada and Mexico.

### **PRE-EXISTING CONDITION LIMITATION**

There is no coverage for a pre-existing condition for a continuous period of 12 months following the effective date of coverage under this Policy.

This limitation does not apply to:

- genetic information in the absence of a diagnosis of the condition related to such information;
- a newborn child who is enrolled in the plan within 31 days after birth, nor to a child who is adopted or placed for adoption before attaining 18 years of age, and as of the last day of the 31-day period beginning on the date of birth, adoption or placement for adoption, is covered under creditable coverage;
- pregnancy; and
- an individual, and any dependent of such individual, who is eligible for a federal tax credit under the federal Trade Adjustment Assistance Reform Act of 2002 and who has three months or more of creditable coverage.

In determining whether a pre-existing condition limitation applies, we will credit the time the covered person was previously covered under creditable coverage, if the previous creditable coverage was: (a) a group health plan; (b) health coverage; (c) Part A or Part B of title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) Chapter 55 of title 10, United States Code; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under chapter 89 of title 5, United States Code; (i) a public health plan, including health coverage provided under a plan established or maintained by a foreign country or political subdivision (as defined in regulations); (j) a health plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)) and coverage under S-CHIP.

Credit for Prior Coverage: A Covered Person whose coverage under prior Creditable Coverage ended no more than 63 days before the Covered Person's effective date under the policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, we will credit only the days of such coverage after the break.

Creditable Coverage means coverage under any of the following:

- a.) any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
- b.) the federal Medicare Program pursuant to Title XVIII of the Social Security Act;
- c.) the Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
- d.) Chapter 55 of Title 10, United States Code, the Civilian Health and Medical Program of the Uniformed Services;
- e.) a medical care program of the Indian Health Service or a tribal organization;
- f.) a state health benefit risk pool;
- g.) a health plan offered under chapter 89 of Title 4, United States Code, Federal Employees Health Benefits Program;
- h.) a public health plan as defined by federal regulations; or
- i.) a health benefit plan under section 5(e) of the Peace Corps Act.

## **PREMIUMS**

Premiums are shown on the Schedule of Benefits. The premium must be remitted to us on or before the premium due date and not more than 31 days after the effective date of the eligible person's coverage. A person's coverage will not be affected by the Policyholder's failure, due to clerical error, to remit premiums to us on time.

Rates are provided on a group basis. Premiums may be changed on any premium due date, on or after the first anniversary, with 60 days advance notice in writing to the Policyholder.

Grace Period: There is a 31 day grace period after each premium due date after the first premium. If a subsequent premium is not paid on time, coverage will stay in force during the grace period. Coverage will end at the end of the grace period, if the premium is not paid by then. If this happens, the premium for the grace period will still be owed to us.

## CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 31 days after a covered loss begins, or as soon as reasonably possible. Notice should include information that identifies the claimant and the policy.

Claim Forms: When we receive notice of claim, we will send forms for filing proof of loss to the claimant. If these forms are not sent within 15 days, the claimant will meet the proof of loss requirements if we are given, within 90 days, written proof of the nature and extent of the loss.

Proof of Loss: Written proof of loss must be given to us within 90 days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to us within 1 year after it is due, unless the Insured is legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by the policy will be paid as soon as we receive proper written proof of such loss.

Payment of Claims — Accidental Death Benefit: Benefits paid on account of an Insured's death will be paid to the beneficiary he has chosen. This choice must be in writing and filed with us, or filed with the Policyholder if we have agreed in advance. The Insured will automatically be the beneficiary for any covered dependents.

If the insured has not chosen a beneficiary, or if there is no beneficiary alive when he dies, we will pay this benefit:

- a.) to his spouse, if living;
- b.) if not, in equal shares to his living children;
- c.) if there are none, in equal shares to his living parents;
- d.) if there are none, in equal shares to his living brothers and sisters;
- e.) if there are none, to his estate.

Instead of a lump sum payment, the Insured (while he is living) or his beneficiary (after the insured's death) may choose installment payments from one of the settlement options we are then offering, if any.

Payment of Claims — Other Benefits: All benefits will be paid to the Insured, unless an Assignment of Benefits has been requested by the Insured. Any other benefits due and unpaid at the Insured's death will be paid to the Insured's estate. Any payment made by us in good faith pursuant to this provision will fully release us to the extent of such payment.

Selection or Change of Beneficiary Assignment: The Insured has the right to select or change a beneficiary. He does not need the consent of the beneficiary to make such change, to assign his rights or benefits, or to change his coverage. We will not be bound by an assignment, or by a selection or change of beneficiary, until we receive a signed copy of it. We are not responsible for its validity or sufficiency.

Physical Examination and Autopsy: At our expense, we may: have a person claiming benefits examined as often as reasonably necessary while the claim is pending; and to make an autopsy in the case of death where it is not forbidden by law.

Legal Action: No legal action may be brought to recover on the policy before 60 days after written proof of loss has been furnished as required by the policy. No such action may be brought after 3 years from the time written proof of loss is required to be furnished.

Misstatement of Age: If the age of the Covered Person is misstated, all amounts payable under the policy shall be such as the premium paid would have purchased at the correct age.

Coordination of Benefits: This provision will be used to determine a Covered Person's benefits under the policy if a Covered Person has health care coverage under more than one plan.

**Explanation.** This coordination of benefits (COB) provision applies when a person has health care coverage under more than one plan "Plan" is defined below. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

### **Definitions**

The following definitions apply to this provision:

- A. A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
- (1) "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of \$200 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
  - (2) "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of \$200 or less per day; school accident type coverage, benefits for non medical components of group long term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law. Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.
- B. The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person. When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.
- C. "Allowable expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
- (1) If a Covered Person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital. and the private room, (unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms) is not an allowable expense.
  - (2) If a Covered Person is covered by 2 or more plans that compute their benefit payments on the basis of Usual and Customary fees, any amount in excess of the highest of the Usual and Customary fees for a specific benefit is not an allowable expense.
  - (3) If a Covered Person is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

- (4) If a Covered Person is covered by one plan that calculates its benefits or services on the basis of Usual and Customary fees and another plan that provides its benefits or services on the basis of negotiated rates, the primary plan's payment arrangements shall be the allowable expense for all plans.
- (5) The amount a benefit is reduced by the primary plan because a Covered Person does not comply with the plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
- D. "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.
- E. "Closed panel plan" is a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

#### **Order of Benefit Determination Rules**

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- A. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- B. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- C. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- D. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
- (1) Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
- (2) Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one plan is:
- (a) The primary plan is the plan of the parent whose birthday is earlier in the year if:
- The parents are married;
  - The parents are not separated (whether or not they ever have been married); or
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If both parents have the same birthday, the plan that covered either of the parents longer is primary.
- (b) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

- (c) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
  - The plan of the custodial parent;
  - The plan of the spouse of the custodial parent;
  - The plan of the noncustodial parent; and then
  - The plan of the spouse of the noncustodial parent.
- (3) Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (4) Longer or shorter length of coverage. The plan that covered the person as an employee, member, subscriber or retiree longer is primary.
- (5) If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

### **Effect on the Benefits of this Plan**

- A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:
  - (1) Determine its obligation to pay or provide benefits under its contract;
  - (2) Determine whether a benefit reserve has been recorded for the covered person; and
  - (3) Determine whether there are any unpaid allowable expenses during that claims determination period. If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to 100% of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.
- B. If a Covered Person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

### **Right to Receive and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Us any facts it needs to apply those rules and determine benefits payable.

### **Facility of Payment**

A payment made under another plan may include an amount that should have been paid under this plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

### **Right of Recovery**

If the amount of the payments made by Us is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

### **GENERAL PROVISIONS**

Not in Lieu of Workers' Compensation: The policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

Termination of Policy: The Policyholder may terminate the policy at any time on or after the first anniversary of the policy's effective date, by sending us written notice. This policy will be terminated on the date we receive the written notice or later if so specified. We may not terminate this policy, other than due to one of the following: a) fraud or misrepresentation; or b) non-payment of premiums or failure to pay premiums according to the terms of the policy; or c) violation of any applicable participation or contribution rules; or d) we terminate all similar group health policies in the State.

Termination will be without prejudice to a claim for benefits for covered charges that were incurred while this policy was in force.

Subrogation: If we paid benefits to a Covered Person for Injuries received in a covered Accident, and in our opinion a third party may be liable, we will be subrogated to the extent of such payment and to all rights of the Covered Person regarding recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered person agrees to sign papers and do whatever is necessary to transfer his rights to us. We will exercise such rights on his behalf. The Covered Person further agrees to furnish us with all relevant information and documents.

Incontestability: The validity of the policy shall not be contested except for nonpayment of premiums after it has been in force for 2 years from its date of issue. All statements made by a Covered Person will, in the absence of fraud, be deemed representations and not warranties. No such statement will be used in defense of any claim or in a contest unless the Covered Person has been given a copy. Any misstatement or omission of information made on the Covered Person's application form or on any other materials on which We relied to issue, change or increase coverage will be considered a misrepresentation and may be the basis for later rescission of coverage. After coverage for a Covered Person has been in force for 2 years during the Covered Person's lifetime, We do not have the right to contest coverage, except for fraud or non-payment of premium.

Representations: In the absence of fraud, any statements made by the Policyholder or Covered Person are deemed representations and not warranties.

Conformity with State Statutes: If any provision of the policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.