University of Medicine and Health Sciences

Student Health Insurance Plan Summary

SUMMARY OF COVERAGES
Policy #22INT06870
TABLE OF BENEFITS

Benefit type	Coverage / Sums Insured Person
Plan Maximums Accident Bodily Injury and Sickness Medical	Per Injury or Sickness US$ 100,000 per Insured Person
Deductible per Injury or Sickness	US$250 per Insured Person Per year
* Deductible is waived in respect of students experiencing COVID 19 type symptoms that require a COVID 19 test recommended by an authorized Medical Practitioner. Deductible applies if student elects to obtain test without referral to either of the above	This provision is only permitted if Students refers to contact GEM to facilitate this treatment Coverage hereon includes COVID 19 test, sample collection and lab test. .
Emergency Room Co-Pay in the U.S	Additional $150 for emergency room, if not admitted
Coinsurance outside the US	Covered expenses paid at 100%
Coinsurance for care provided in the United States	Benefits will be paid for 80% of Covered Medical Expenses incurred up to US$10,000. Thereafter, 100% of any Covered Medical Expenses up to the Plan Maximum will be paid if treatment in-network and 80% if not in network subject at all time to the pre-authorisation of the Claims Management Company. Additional US$ 150 co-pay for emergency room if not admitted. .
Benefit Period	Covered Expenses incurred during the Insured Person period
Inpatient	
Hospital Expenses	Usual and Customary (U & C) up to plan maximum
Intensive care	Paid under Hospital Expenses
Routine Newborn Care	Paid as any other Sickness / 4 days Hospital Confinement expense maximum
Physiotherapy	Usual, Reasonable and Customary subject the Policy maximum
Surgeon’s Fees	Usual, Reasonable and Customary subject the Policy maximum
Assistant Surgeon	Usual, Reasonable and Customary up to $1,000
Anaesthetist	Usual, Reasonable and Customary subject the Policy maximum
Registered Nurse’s Services	Usual, Reasonable and Customary subject the Policy maximum
Physician's Visits	Usual, Reasonable and Customary subject the Policy maximum
Pre-admission Testing	Usual, Reasonable and Customary subject the Policy maximum
Outpatient	
Surgeon’s Fees	Usual, Reasonable and Customary subject the Policy maximum
Day Surgery Miscellaneous	Usual, Reasonable and Customary US$ 1,500 maximum
Assistant Surgeon	U&C to $1,000
Anaesthetist	Usual, Reasonable and Customary subject the Policy maximum
Physician’s Visits	Usual, Reasonable and Customary subject the Policy maximum
Physiotherapy	Usual, Reasonable and Customary but limited to one visit per day up to 12 visits per injury or sickness for injuries or Sicknesses that required surgery or hospitalization
Medical Emergency Expenses	Usual, Reasonable and Customary subject the Policy maximum
Diagnostic X-ray and Laboratory Services	Usual, Reasonable and Customary subject the Policy maximum Usual, Reasonable and Customary subject the Policy maximum

Radiation Therapy and Chemotherapy	Usual, Reasonable and Customary subject the Policy maximum
Tests and Procedures	Usual, Reasonable and Customary subject the Policy maximum
Injections, when administered in the Physician's office and charged on the Physician's statement	Usual, Reasonable and Customary US$ 5 deductible per injection
Prescription Drugs	Usual, Reasonable and Customary US$ 100 deductible in lieu of the Policy Deductible
Psychotherapy (Mental Illness)	
Inpatient	Usual, Reasonable and Customary up to a maximum US$ 7,500 per person, per policy year
Outpatient	Usual, Reasonable and Customary $100 per day to a maximum up to US$ 1,500 per person, per event
Other	
Ambulance Services	Usual, Reasonable and Customary subject the Policy maximum
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Replacement equipment is not covered	Usual, Reasonable and Customary subject the Policy maximum
Consultant Physician Fees	No Benefit
Dental (Palative)	Usual, Reasonable and Customary US$ 100 per tooth / up to US$ 500 per policy year
Chemical Dependency	Usual, Reasonable and Customary up to a maximum of $15,000 per insured person
Maternity	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness
Interscholastic Sports	No Benefit
Child Health Supervision Services	See Benefits for Child Health Assurance
Elective Abortion	Usual, Reasonable and Customary US$ 500 lifetime maximum

MAXIMUM BENEFIT

The maximum aggregate amount payable for any one Insured Person by Us for all incurred Covered Medical Expenses for Accidental Bodily Injury or Sickness will never exceed $100,000 excluding any Deductible or Co-Insurance paid by the Insured Person.

POLICY DEDUCTABLE AND CO-PAY AMOUNTS

There is a $250 per person per year excess per injury or sickness
There is additional US$ 150 co-pay for emergency room if You are not admitted for treatment
Benefits will be paid for 80% of Covered Medical Expenses incurred up to US$10,000. Thereafter, 100% of any Covered Medical Expenses up to the Plan Maximum will be paid if treatment in-network and 80% if not in network subject at all time to the pre-authorisation of the Claims Management Company.

INSURANCE POLICY WORDING

INSURING AGREEMENT

In return for You having paid the premium to the Participating Organisation for the Coverage Period stated in the Certificate of Insurance, We will provide You the Benefits set out in Your Policy subject to the Definitions, Condition, Benefits limits and Exclusion contained in Your Policy.

Your Insurance Policy, which with Your Certificate of Insurance should be read together and forms the contract of Insurance between You and Us but is only valid if You have paid the premium.

Your premium has been based on the information shown in Your Certificate of Insurance and recorded in the written declaration You have made. Please read them carefully to make sure they meet Your requirements and that the details on Your certificate of Insurance are correct. If after reading Your Policy and Certificate of Insurance You have any questions, please contact your insurance advisor.

JURISDICTION AND CHOICE OF LAW

This insurance shall be governed by and construed in accordance with the law of St Kitts and Nevis and shall be subject to the jurisdiction of the courts of St Kitts and Nevis

COOLING OFF PERIOD/MONEY BACK GUARANTEE

If You decide that You do not want this policy, You may cancel it within14 days after the issue of Your Certificate of Insurance and of the policy wording to You, and You will be given a full refund of the premium You paid, provided You have not started Your journey and You do not want to make a claim or to exercise any other right under the policy.
After this period You can still cancel Your policy but We will not refund any part of Your premium if You do.

COMPLAINTS PROCEDURE

Our Service to You

Our goal is to give excellent service to all Our customers but We recognize that things do go wrong occasionally. We take all complaints We receive seriously and aim to resolve all of Our customers' problems promptly. To ensure that We provide the kind of service You expect We Welcome Your feedback. We will record and analyse Your comments to make sure We continually improve the service We offer.

What is a complaint?

A Complaint is an expression of dissatisfaction not resolved to Your satisfaction within 48 hours.
This does not include normal claims negotiation where offers are rejected/discussed unless You specifically state the matter is to be treated as a complaint or if negotiations have reached deadlock.
A complaint does include the rejection of a claim or the settlement amount for a claim where the parties have reached deadlock in negotiations and where You believe You have been offered a poor service.

Who to tell

In the event of You having a complaint please contact Us by addressing Your complaint to Our "Complaints Department" at Our registered address, set out above. We will acknowledge Your complaint promptly.

What happens next

We will write directly to You to acknowledge receipt of the complaint and explain the complaints process. We will investigate by requesting information / evidence where needed from the parties involved and will write directly to You with any updates. We will then issue You with Our final response to Your complaint.

If You remain dissatisfied with the Our final response, You may be entitled to refer the matter to the Financial Ombudsman Service (FOS). Following this complaints procedure, does not affect Your right to take legal action.

Please note, the FOS will only consider a complaint if We have issued Our final response to Your complaint or eight Weeks have elapsed since We received the complaint.

The FOS's contact details are:
Financial Ombudsman Service, South Quay Plaza, 183 Marsh Wall, London, E14 9SR
Website: www.financial-ombudsman.org.uk
email: complaint.info@financial-ombudsman.org.uk
phone: 0800 023 4567 or 0300 123 9123

Financial Services Compensation Scheme (FSCS)
The Insurer is a member of the FSCS. You may be entitled to compensation from FSCS in the event We are unable to meet Our obligations.

The FSCS's contact details are:
Financial Services Compensation Scheme,10th Floor, Beaufort House, 15 St Botolph Street, London, EC3A 7QU
Website: www.fscs.org.uk
phone: 0800 678 1100 or 020 7741 4100

IN THE EVENT OF A CLAIM:

IMMEDIATE NOTICE should be given

MEDICAL EXPENSES

To provide you with a local and efficient service, we have selected Global Excel Management. as our Medical Claims Management Company to administer Your Travel Insurance Policy on our behalf.

Members can call Global Excel Management's multilingual Customer Service center which is available 24 hours a day, 7 days a week:

Inside the USA:

Toll Free Number (for use in the USA): +1-877-839-5585

Outside the USA:

Local Number (for calls Outside the USA): +1-305-428-2838

For all non-emergency reimbursement claims

Address for claims:

73 Queen Street, Sherbrooke (Quebec), J1M 0C9 Canada

Tel: +1-877-839-5585

Global Excel Management will have access to your policy details and will be able to confirm if you have cover for any treatment required in the USA and Canada. Global Excel Management will also deal directly with local medical providers to co-ordinate the direct settlement of all your eligible medical treatment.

Non-Emergency Care

When you need to seek non-emergency care (i.e., cold, flu, minor injuries and sickness), please visit a local doctor, urgent care treatment center or walk-in medical clinic.

You can locate a provider online at http://www.globalexcel.com/providers/ or call Global Excel Management at 1-800-250-3271 for appropriate providers in your area.

Emergency Care

If an Insured Person needs to seek emergency care (i.e., serious accidents or sickness, and any condition that requires an ambulance), please go to the nearest hospital emergency room or call the emergency services (911 in the USA) for immediate assistance.

Provide them with your insurance information at the time of treatment.

ID Card

It is extremely important that an Insured Person always carries their insurance Aetna ID card with them and present it to the medical services providers involved in their care in order to avoid any unnecessary out-of-pocket expenses incurred by themselves .

The ID card will be given to an Insured Person before they travel and should be always kept with them.

Providers

Inside the USA, you can search for providers in your network online at http://www.globalexcel.com/providers/ or call Global Excel Management at 1-800-250-3271 for assistance in locating a provider in your area.

For providers in Canada, please contact Global Excel Management at 1-800-250-3271 for assistance in locating a provider in your area.

Prior Authorization

Prior authorization is required for all hospitalizations; surgeries and scheduled procedures; diagnostic testing/imaging (i.e., CT scan, MRI, PET scan, etc.); oncology services (i.e., chemotherapy, radiation) and high-cost specialty prescribed medications.

An Insured Person or the provider must contact Global Excel Management to start the prior authorization process in order to avoid any unnecessary out-of-pocket expenses. The provider will need to provide the pertinent medical documentation for their claim to be properly assessed.

Discount pharmacy card (for US prescription drugs only)

You can apply for a discount pharmacy card from Global Excel Management and benefit from an average saving of 20% off the regular retail price of many prescription drugs in the US only. This discount card can be used any time your prescription is not covered by your healthcare policy. There are no restrictions on how many times you may use this card and it is accepted by 9 out of 10 pharmacies nationwide. To register and obtain your discount pharmacy card, simply go to: www.omhc.com/interhannover, click on ‘Prescriptions’ and then on ‘Print Discount Card’.

Receiving statements or invoices at home

It is normal to receive a statement at home after visiting a doctor or hospital to inform you of the amount your insurance company is being charged via direct settlement for the services you received. This statement is for your information only and there is nothing for you to do unless the treatment described in the statement does not correspond with the treatment you actually received, in which case please contact Global Excel Management.

In some instances, you may receive an invoice at home, if your provider is independent of your main hospital (e.g. laboratories, pathology providers etc., who may not hold details of your insurance policy). If you receive an invoice at home, please inform Global Excel Management by calling: **1-800- 250-3271**. Global Excel Management will then liaise directly with the provider to settle all outstanding, eligible invoices.

IN-NETWORK PROVIDER INFORMATION

"In Network Providers" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices with Our Medical Claims Management Company
The availability of specific providers is subject to change without notice. Insured Person should always confirm that an In-Network Provider is participating at the time services are required by calling GEM and/or by asking the provider when making an appointment for services.

"Preferred Allowance" means the amount an In Network Provider will accept as payment in full for Covered Medical Expenses.

"Out of Network" providers have not agreed to any prearranged fee schedules. Insured Person may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured Person's responsibility. Regardless of the provider, each Insured Person is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid. We will pay according to the benefit limits in the Schedule of Benefits.

Inpatient Hospital Expenses

Preferred Hospitals - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at the coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call GEM for information about Preferred Hospitals.

Out of Network Hospitals - If care is provided at a Hospital that is not an In Network Provider, eligible inpatient Hospital expenses will be paid according to the benefit limits in the Schedule of Benefits subject always to the prior approval of GEM..

Outpatient Hospital Expenses
In Network Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insured Persons are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

Professional & Other Expenses
Benefits for Covered Medical Expenses provided by Us will be paid at the coinsurance percentages specified in the Schedule of Benefits, or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

You can choose Your own Physician
You are free to choose Your own Physician or We can appoint a Physician to see You,
You must, however, advise GEM of Your admittance to hospital or your early return to Your country of residence based on medical advice. If You do not get the medical treatment You expect, GEM can assist You but We (the Insurer) and the agent of the Insurer, are not liable for anything that results from that.

HOW TO MAKE A CLAIM

1. As soon as reasonably possible after the happening of any incident likely to give rise to a claim under this Policy (but in any event no later than 60 days after the date discovery of loss) You must notify Our Medical Claims Management Company of such incident.
2. You must at Your own reasonable expense furnish them such certificates, information and evidence as they may from time to time reasonably require in the form prescribed by Us. They shall be allowed at their own expense, upon reasonable notice to request a medical examination of You as appropriate.
3. You shall as soon as reasonably possible after the occurrence of any Accidental Bodily Injury or after You become aware of any Sickness obtain and follow the advice of a Medical Practitioner and We shall not be liable for any consequences of Your failure to so obtain and follow such advice.
5. We are entitled to take over any rights in defence or settlement of any claims and to take proceedings in Your name for Our benefit against any other party.
6. We will process Your claim within 10 business days of receiving a claim form completed in accordance with these claims provisions.
7. You shall provide such reasonable cooperation to Our Medical Claims Management Company as they may reasonably request including by permitting them access to medical documentation, reports and evidence in relation to Your claim. We may deny coverage for any claim where there has been an unreasonable refusal or material failure to so cooperate.

Proof of Claim
When Our Medical Claims Management Company receives notice of claim, they will ask You to provide the following information:

1. Original itemized bills from Physicians, Hospitals and other medical providers; and
2. Original receipts for any expenses which have already been paid by or on behalf of You.

You shall have 60 days beginning on the last day of the Coverage Period to submit Proof of Claim to Medical Claims Management Company, unless medical services were rendered after this Coverage Period, in which case You shall have 60 days from the date the service Were rendered to submit the Proof of Claim.

If any claim under this insurance shall be in any respect fraudulent or if any fraudulent means or devices are Used by You or anyone acting on their behalf, this insurance shall be null and void and all claims hereunder shall be forfeited, in addition to any and all other remedies available to Us.

Claims Processing
We will process Your claim within 10 business days of receiving a completed claim form and all necessary documentation. If We need additional information, a written notification will be sent to You within10 business days.

Data Protection

The basics
We collect and use relevant information about **you** to provide **you** with **your** insurance cover or the insurance cover that benefits **you** and to meet **our** legal obligations.
This information includes details such as **your** name, address and contact details and any other information that **we** collect about **you** in connection with the insurance cover from which **you** benefit. This information may include more sensitive details such as information about **your** health and any criminal convictions **you** may have.
The way insurance works means that **your** information may be shared with, and used by, a number of third parties in the insurance sector for example, insurers, agents or insurance **broker** s, reinsurers, loss adjusters, sub-contractors, regulators, law enforcement agencies, fraud and crime prevention and detection agencies and compulsory insurance databases. **we** will only disclose **your** personal information in connection with the insurance cover that **we** provide and to the extent required or permitted by law.
Other people's details you provide to us
Where **you** provide **us** or **your** insurance **broker** with details about other people, **you** must provide this notice to them.
Want more details?
For more information about how **we** use **your** personal information please see **our** full privacy notice(s), which is/are available online on **our** website(s) or in other formats on request.
Contacting us and your rights
You have rights in relation to the information **we** hold about **you**, including the right to access **your** information. If **you** wish to exercise **your** rights, discuss how **we** use **your** information or request a copy of **our** full privacy notice(s), please contact **us**, or **your** insurance **broker** who will provide **you** with **our** contact details.
In this insurance **our** syndicate numbers and proportions are shown in the attached table. **We** bind **our**selves severally and not jointly, that is, in the event of a claim, each of **us** (and **our** Executors and Administrators) is liable only for their own share of their syndicate's proportion of the risk.
You or **your** representative can obtain the name of each of **us** and **our** respective shares by applying to Market Services, Lloyd’s, One Lime Street, London EC3M 7HA.
We are authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and Prudential Regulation Authority.
Our Firm Reference Number(s) and other details can be found on the Financial Services Register at www.fca.org.uk

Personal information:
Your personal information means any information We hold about You and the Insured Person(s). This information may be contained in any correspondence received from You including letters and emails. We have implemented technical, physical, legal and organisational measures where necessary to secure the personal information We hold and process on Your behalf. Where appropriate We use anti-virus protection systems, firewalls, pseudonymisation and data encryption technology for the processing and storage of electronic personal information. Where We hold hard copy documentation containing Your personal information (whether on or off site) we will ensure that the relevant documentation is physically secured and accessible only on a “need to know” basis. Our staff are trained regularly on data protection and information security.
You should show this section to anyone else insured or proposed to be insured under Your policy as it will also apply to them. It explains how We use all the information We have about You and the other people insured under Your Policy.

Special category data:
Some of the personal information that We ask You to provide is known as “special category data”. This will include information relating to Your health or medical condition(s) and may also include, race, religion and any criminal convictions. We need to use special category data to provide You with quotes, arrange and manage Your policy and to provide the services described in Your policy documents (such as dealing with claims). Where You have provided Us with special category data relating to someone else, You undertake that You have obtained their express consent to provide Us with this data.

How We use Your personal information:
We will use Your personal information to arrange, administer and manage Your insurance policy, including handling underwriting and claims and issuing renewal documents and information to You. The personal information We hold about You is limited to what is necessary to provide these services. We erase the personal information We hold about You as soon as it is no longer needed in accordance with our legal and statutory obligations.

Sharing Your personal information:
We may have to share Your personal information with other insurers, statutory bodies, regulatory authorities, Our business partners, Our group companies or agents providing services on Our behalf and other authorised bodies. Where We do share Your personal data with others We will ensure that the appropriate safeguards are in place.
Transferring Your personal information outside the EEA:
To manage Your policy including settling claims or providing Security or Medical Assistance if the claim or assistance relates to an incident which occurs outside Your Country of Domicile We may transfer Your personal information outside the European Economic Area or if different Your Country of Domicile. We will only do this;

- If You have given Us Your permission;
- For underwriting purposes, such as assessing Your application and arranging Your policy;
- For management information purposes;
- If the transfer is necessary for reasons of public interest;
- To prevent or detect crime, including fraud (see below);
- If We are required or permitted to do this by law (for example, if We receive a legitimate request from the police or another authority including legal authorities outside the European Economic Area or, if different, Your Country of Domicile); and/or if required

Where it is necessary to transfer your data outside of the EEA we will ensure that appropriate safeguards are in place.
Preventing and detecting crime:
We may use Your personal information to prevent crime.
In order to prevent crime We may:

- Check Your personal information against Our databases;
- Share it with fraud prevention agencies. Your personal information will be checked with and recorded by a fraud prevention agency. Other companies within the financial services industry may also search such fraud prevention agencies when You make an application to them for financial products (including credit, savings, insurance, stockbroking or money transmission services). If such companies suspect fraud, We will share Your relevant personal information with them. The information We share may be used by those companies when making decisions about You. You can find out which fraud prevention agencies are used by Us by writing to Our Data Protection Contact at the address set out below; and/or if required:
- Share it with operators of registers available to the insurance industry to check information and prevent fraud. These include the Claims and Underwriting Exchange Register administered by Insurance Database Services Ltd. We may pass information relating to Your insurance policy and any incident (such as an accident, theft or loss) to the operators of these registers, their agents and suppliers.

Dealing with others on Your behalf:
To help You manage Your insurance policy, subject to answering security questions, We will deal with You or Your spouse or partner or any other person whom We reasonably believe to be acting for You if they contact Us on Your behalf in connection with Your policy or a claim relating to Your policy. Where We have reasonable doubts concerning the identity of Your spouse or partner or such other person claiming to be acting on Your behalf, we may request additional information necessary to confirm their identity before we release any information in relation to Your policy to them. For Your protection only You can cancel Your policy or change the contact address.

Marketing:
We will not use Your personal information and information about Your use of Our products and services to carry out research and analysis for marketing.
Data Protection Rights:
You have certain rights under the GDPR.
You have the right to require Us to:

- Provide You with further details about the use We make of Your personal data;
- Provide You with a copy of the personal data We hold in a commonly used and machine readable format;
- Correct any inaccuracies in the personal data We hold;
- Delete any personal data We no longer have any lawful ground to use;
- Where the processing requires Your consent, withdraw that consent so We stop the processing in question;
- Transfer Your personal data to another organization;
- Object to any processing based on the legitimate interests grounds unless our reasons for that processing outweigh any prejudice to Your data protection rights;
- Object to automated processing, including profiling; and/or
- Restrict how We process or use Your personal data in certain circumstances e.g. whilst a complaint is being investigated.

In certain circumstances we may need to restrict the above rights to safeguard the public interest (e.g. prevention or detection of crime) or Our interests (e.g. legal or litigation privilege).

If you are not satisfied with Our use of Your personal data or Our response to any request by You to exercise any of Your rights, or if You think We have breached the GDPR, You have the right to complain to the ICO, details as follows:

England	Scotland	Wales	Northern Ireland
Information Commissioner's Office Wycliffe House Water Lane Wilmslow Cheshire SK9 5AF	Information Commissioner's Office 45 Melville Street Edinburgh EH3 7HL	Information Commissioner's Office 2nd Floor Churchill House Churchill Way Cardiff CF10 2HH	Information Commissioner's Office 3rd Floor 14 Cromac Place Belfast BT7 2JB
Tel: 0303 123 1113 (local rate) or 01625 545 745 (national rate)	Tel: 0131 244 9001	Tel: 029 2067 8400	Tel: 0303 123 1114 (local rate) 028 9027 8757 (national rate)
casework@ico.org.uk	scotland@ico.org.uk	wales@ico.org.uk	ni@ico.org.uk

Further information:
If You would like to receive a copy of the personal information We hold on You, or if You would like further information or wish to complain about the way that We use personal information, please write to Our Data Protection Contact (set out below).
If We change the way that We use Your personal information, We will write to You to let You know. If You do not agree to that change in use, You must let Us know as soon as possible. You have the right to complain to Us at any time if You object to the way We use Your personal information. If you do, We will no longer be able to process the personal information We hold about You unless We are able to demonstrate compelling legitimate grounds for the continued processing of Your personal information which override Your interests, rights and freedoms of You, or for the establishment, exercise or defence of legal claims.

Contacting Our Data Protection Contact
To contact Our Data Protection Contact please write to Us at Dale Underwriting Partners, 6th Floor Bevis Marks, 6 Bevis Marks, London EC3A 7BA, UK giving Your name, address and insurance policy number.

POLICY CONDITIONS

Benefit payments
All benefits will be paid directly to You unless Our Medical Claims Management Companies have guaranteed Your expenses or charges and has made payment on Our behalf. In the event of Your death any benefits payable will be made to Your executors or administrators. In the event of You not having an executor or administrator the benefits will be paid out in accordance with the inheritance laws of Your Home Country.

Currency
The monetary limits stated in the Policy and Certificate of Insurance issued hereunder are in US dollars.

Contribution
If at the time of an event giving rise to a claim there is any other insurance policy, reciprocal health arrangement or governmental health or workmen's compensation scheme in force in Your name which covers You for the same expense, loss or liability We will only pay our share of the claim determined by reference to the cover provided by each of the relevant policies. If You make a claim under one insurance policy and You are paid the full amount of Your claim, You cannot make a claim under the other policy

Effective Date
Insurance under this policy shall become effective on the later of the following dates:
1) The Effective Date of the Certificate of Insurance; or
2) The date premium is received by the Administrator.

Dependent coverage will not be effective prior to that of the Insured Person

Eligibility Criteria
Each person who belongs to one of the "Classes of Persons to be Insured " as set forth in the application is eligible to be Insured Person under this policy. The Insured Person must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, Internet, and television (TV) courses do not fulfil the eligibility requirements that the Insured Person actively attend classes. We maintains the right to investigate student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever We discover that the policy eligibility requirements have not been met, its only obligation is refund of premium.

The eligibility date for Dependents of the Insured Person (as defined) shall be determined in accordance with the following:
1) If an Insured Person has Dependents on the date he or she is eligible for insurance; or
2) If an Insured Person acquires a Dependent after the Effective Date, such Dependent becomes eligible:
(a) On the date the Insured Person marries the Dependent; or
(b) On the date the Insured Person acquires a dependent child who is within the limits of a dependent, unmarried child set forth in the "Definitions" section of this policy.

Dependent eligibility expires concurrently with that of the Insured Person.

Eligible persons may be Insured Person under this policy subject to the following:
1) Payment of premium as set forth on the policy application; and,
2) Application to the Company for such coverage.

Fraudulent claims.
If any claim under this insurance shall be in any respect fraudulent or if any fraudulent means or devices are Used by You or anyone acting on their behalf, this insurance shall be null and void and all claims hereunder shall be forfeited, in addition to any and all other remedies available to Us

Health Insurance Business
Student health insurance coverage, offered by the Company may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy.
Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are $250,000 for policy years before September 23, 2012 and $500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of $100.000 for each Injury or Sickness that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If You have any questions or concerns about this notice, contact Customer Service at 819-566-1130. Be advised that You may be eligible for coverage under a

group health plan of a parent's employer or under a parent's individual health insurance policy if You are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

Maternity Testing
This policy does not cover all routine, preventive, or screening examinations or testing. The following maternity tests and screening exams will be considered for payment according to the policy benefits if all other policy provisions have been met.

Initial screening at first visit:
• Pregnancy test: urine human chorionic gonatropin (HCG)
• Asymptomatic bacteriuria: urine culture
• Blood type and Rh antibody
• Rubella
• Pregnancy-associated plasma protein-A (PAPPA) **(first trimester only)**
• Free beta human chorionic gonadotrophin (hCG) **(first trimester only)**
• Hepatitis B: HBsAg
• Pap smear
• Gonorrhea: Gc culture
• Chlamydia: chlamydia culture
• Syphilis: RPR
• HIV: HIV-ab
• Coombs test
Each visit: Urine analysis
Once every trimester: Hematocrit and Hemoglobin
Once during first trimester: Ultrasound
Once during second trimester:
• Ultrasound (anatomy scan)
• Triple Alpha-fetoprotein (AFP), Estriol, hCG or Quad screen test Alpha-fetoprotein (AFP), Estriol, hCG, inhibin-a
Once during second trimester if age 35 or over: Amniocentesis or Chorionic villUs sampling (CVS)
Once during second or third trimester: 50g Glucola (blood glucose 1 hour postprandial)
Once during third trimester: Group B Strep Culture
Pre-natal vitamins are not covered.

Medical Advice
You cannot travel against the advice of Your Physician or after You have received a terminal prognosis or if You are travelling purely for the purpose of medical treatment. If You choose to do so all Our liability under this Policy shall cease.

Pre-authorization requirements for treatments, costs charges or expenses.
All Inpatient Hospital treatments or care, Surgery or Surgical Procedure, computerized tomography (CAT Scan) and Magnetic Resonance Imaging (MRI), must be pre-authorized by Global Excel Management (GEM)

If You do not comply with this pre-authorization requirement We will be unable to pay for Your treatments or costs, charges or expenses that You incur.

To comply with the pre- authorization requirements, You or a third party must:

1. Contact GEM at the telephone number contained in Your Certificate as soon as possible before the expense is to be incurred; and
2. Comply with the reasonable instructions of GEM and submit any information or documents they may reasonably require; and
3. Take reasonable steps to notify Your treating Physicians, Hospitals and other providers that this Policy contains pre-authorization requirements and ask them to fully cooperate with GEM.

If in an emergency it is not reasonably possible for You to obtain pre-authorization from GEM for Inpatient Hospital treatments or care, Surgery or Surgical Procedure, You or a third party must notify them as soon as reasonably practicable after Your admission as an In-patient in which case all Your charges will be paid by Us subject to the terms and conditions, benefit limits, restrictions and exclusions contained in this Policy.

Right of Recovery
We will apply any money We recover from someone else under a right of subrogation in the following order:
1. Our administration and legal costs arising from the recovery.
2. Your uninsured loss (less Your excess if applicable).
3. The amount We paid You for Your claim.

4. Your Co-Insurance or Deductible (if applicable).
Once We pay Your total loss We will keep all money left over.
If We have paid Your total loss and You receive a payment from someone else for that loss or damage, You must pay Us the amount of that payment up to the amount of the claim We paid You.
If We pay You for lost or damaged property and You later recover the property or it is replaced by a third party, You must pay Us the amount of the claim We paid You.

Right of Repatriation
In the event of You requiring any medical treatment or, Hospital or medical services, We reserve the right to arrange Your return to Your Home Country either before or after You receive medical treatment or Hospital or medical services if in the opinion of Our Medical Claims Management Company and Your treating Physician You are medically fit to travel and it is safe for You to do so. If You refuse to return when declared medically fit to do so We will not pay for any continuing medical treatment or Hospital or medical services or any recurrence or complications arising from or directly or indirectly related thereto..

Subrogation
We may, at our discretion undertake in Your name and on Your behalf, control and settlement of proceedings for our own benefit in Your name to recover compensation or secure indemnity from any party in respect of anything covered by this policy. You are to assist and permit to be done, all acts and things as required by Us for the purpose of recovering compensation or securing indemnity from other parties to which We may become entitled or subrogated, upon Us paying Your claim under this policy regardless of whether We have yet paid Your claim and whether or not the amount We pay You is less than full compensation for Your loss.
These rights exist regardless of whether Your claim is paid under a non-indemnity or an indemnity clause of this policy.

Sanction Limitation and Exclusion Clause
We shall not provide cover or pay or be liable for any claims or provide any benefit under this Policy if by providing any cover, paying any claims or providing any benefit under this Policy would expose Us to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

Termination of Cover:
Cover under this Policy terminates on the earlier of:
1) The End Date day of the period through which the premium is paid; or
2) The date the policy terminates.

The coverage provided with respect to any Dependent shall terminate on the earliest of the following dates:
1) The last day of the period through which the premium is paid;
2) The date the policy terminates; or
3) The date the Insured Person Person's coverage terminates.

Continuation Privilege
In the event an Insured Person, who has been a continuously Insured Person under this policy for at least six consecutive months, no longer meets the Eligibility requirements because between stated term dates, classes are not being held, the Company will allow that Insured Person to continue to purchase cover for up to a maximum period of six months until classes start again and they meet the Eligibility requirement. Provided that such Insured Person has notified the Company of any losses or does not know of any potential losses or any incident that would have led to a claim under this policy and the continuation period does not exceed the date in which this policy terminates with the Company.

It is a condition of this Extension that during the continuation period the Insured Person does not fully complete their studies with the Participating Organization and intends returning to study with the Participating Organization once classes resume and does not take up full time employment or enroll with a different educational establishment."

If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured Person must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to rates and benefits selected by the school for that policy year.

WORD AND PLAN DEFINITIONS

Some words in Your policy that have special meanings are defined here.

ACCIDENT/ACCIDENTAL means a sudden, unintentional and unexpected occurrence caused by external, visible means and resulting in Your physical Injury.

BODILY INJURY means injury which is sustained by You as the result of an Accident which solely and independently of any other cause except surgical treatment rendered necessary by the Accident results in Your death, disablement or injury that incurs Medical Expenses.

ADOPTED CHILD means the adopted child placed with an Insured Person while that person is covered under this policy. Such child will be covered from the moment of placement for the first 31 days. The Pre-existing Conditions limitation will not apply to an adoptive child. The Insured Person must notify the Company, in writing, of the adopted not more than 30 days after placement or adoption.
In the case of a newborn adopted child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Insured Person prior to the birth of the child, whether or not the agreement is enforceable. However, coverage will not continue to be provided for an adopted child who is not ultimately placed in the Insured Person's residence.
The Insured Person will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured Person must, within the 31 days after the child's date of placement: 1) apply to Us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured Person does not Use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's date of placement.

AMATEUR ATHLETICS means a sport or other athletic activity that is organized and/or sanctioned, involving regular or scheduled practices and/or regular or scheduled games. This definition does not include either athletic activities that are engaged in by You solely for recreational, entertainment or fitness purposes and not for wage, reward or profit.

BENEFIT PERIOD shall mean the allowable time period You have to receive treatment for a Covered Injury or Sickness.

CHEMICAL DEPENDENCY means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

CLAIMS MANAGEMENT COMPANY Global Excel Management (GEM)

COINSURANCE (Co-pay) shall mean the percentage amount of Covered Expenses, after the Deductible, which is Your responsibility to pay.

COMPANY shall mean Dale Underwriting Partners

COMPLICATION OF PREGNANCY means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy. The term "complication of pregnancy" includes non-elective caesarean section; therapeutic abortion; ectopic pregnancy which is terminated; spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; hyperemesis gravidarum; and, pre-eclampsia.

CONTACT SPORT means a sport or other athletic activity that necessarily involves physical contact with opposing players as part of normal play.

COVERAGE PERIOD means the period of time You are covered under this Policy of Insurance starting on the Effective Date and ending on the End Date..

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are Medical

Necessary; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any.
Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply per policy year or per occurrence (for each Accidental Bodily Injury or Sickness) as specified in the Schedule of Benefits.

DEPENDENT means the spouse (husband or wife) of the Insured Person and their dependent, unmarried children. Children shall cease to be dependent on the first to occur of:
1) The end of the month in which they marry; or,
2) The end of the month in which they attain the age of nineteen (19) years.
The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both:
1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and,
2) Chiefly dependent upon the Insured Person for support and maintenance.
Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Insured Person; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child's attainment of the limiting age.
If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

EFFECTIVE DATE means the date sated on Your Certificate of Insurance when Your cover starts under this Policy of Insurance.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

END DATE means the End Date specified on Your Certificate of Insurance when Your cover under this Insurance Policy ceases.

HOME COUNTRY shall mean the country where You have Your true, fixed and permanent home and principal establishment.

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home, or an institution specializing in or primarily treating Mental and Nervous Disorder.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confined in a Hospital for at least 18 hours by reason of an Injury or Sickness for which benefits are payable.

INJURY means Bodily Injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Insured Person is covered under this policy.
All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

INPATIENT shall mean if You are confined in an institution and are charged for room and board.

INSURED PERSON means: 1) the Insured Person; and, 2) Dependents of the Insured Person, if: 1) the Dependent is properly enrolled in the program, and 2) the appropriate Dependent premium has been paid. The term "Insured Person" also means Insured Person.

INTENSIVE CARE means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily Used for patient confinement. They must be:
1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:
1) Progressive care;
2) Sub-acute intensive care;
3) Intermediate care units;
4) Private monitored rooms;
5) Observation units; or
6) Other facilities which do not meet the standards for intensive care.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in:
1) Death;
2) Placement of the Insured Person's health in jeopardy;
3) Serious impairment of bodily functions;
4) Serious dysfunction of any body organ or part; or
5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.
Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfils the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

MEDICALLY NECESSARY means those services or supplies provided or prescribed by a Hospital or Physician which are:
1) Essential for the symptoms and diagnosis or treatment of the Sickness or Injury;
2) Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury;
3) In accordance with the standards of good medical practice;
4) Not primarily for the convenience of the Insured Person, or the Insured Person's Physician; and,
5) The most appropriate supply or level of service which can safely be provided to the Insured Person.
The Medical Necessity of being Hospital Confined means that: 1) the Insured Person requires acute care as a bed patient; and, 2) the Insured Person cannot receive safe and adequate care as an outpatient.
This policy only provides payment for services, procedures and supplies which are Medical Necessary. No benefits will be paid for expenses which are determined not to be Medical Necessary, including any or all days of Hospital Confinement.

MENTAL AND NERVOUS DISORDER means a Sickness that is a mental, emotional or behavioural disorder. If not excluded or defined elsewhere in the policy, all diagnoses classified as a "Mental Disorder" according to the (International Classification of Diseases) are considered one Sickness.

INSURED PERSON means an eligible, registered student of the Participating Organisation, if: 1) the student is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid. who have arranged their travel through the Participating Organization with the specific reason of travel abroad for study, language study, educational and cultural exchange, work experience abroad (both summer and winter), internships and Au pairs

NEGATIVE X-RAY means an X-ray that shows the absence of a fracture; pathology; or disease.

NEWBORN INFANT means any child born of an Insured Person while that person is Insured Person under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.
The Insured Person will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured Person must, within the 31 days after the child's birth: 1) apply to Us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured Person does not Use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth.

NON-HOSPITAL RESIDENTIAL FACILITY means a facility accredited in the local jurisdiction where it is located as a qualified non-hospital provider of treatment for chemical dependency, mental illness, or any combination of these, in any residential setting

OUTPATIENT shall mean if You receive care in a Hospital or another institution, including; ambulatory surgical centre; convalescent/skilled nursing facility; or Physician’s office, for an Injury or Sickness, but who is confined and is not charged for room and board.

OUTPATIENT TREATMENT FACILITY means a clinic, counseling center, or other similar location that is accredited in the local jurisdiction where it is located as a qualified provider of outpatient services for the treatment of chemical dependency, or mental illness.

PARTICIPATING ORGANIZATION means the International University of Nursing, St. Kitts who provides the Insured Persons with classes and home study courses to study medicine and who submits an application for insurance on behalf of the Insured Person, collects and pays the premium charged to the Insured Person and receives a Certificate of Insurance issued by The Company, and provides each and every Insured Person who is covered with a Summary of Benefits, as provided by The Company.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.
The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PHYSIOTHERAPY means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

POSITIVE X-RAY means an X-ray that shows the presence of a fracture; pathology; or disease.

PRE-EXISTING CONDITION means: 1) a condition which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 months immediately prior to the Insured Person's Effective Date under the policy; or, 2) any condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately prior to the Insured Person's Effective Date under the policy. However, the Effective Date for determining if this condition applies shall be the date the Insured Person was first enrolled as an Eligible Person by the Policy Holder.

PRESCRIPTION DRUGS means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

PSYCHOTHERAPY means the treatment of a Mental and Nervous Disorder. Psychotherapy includes all related or ancillary charges incurred as a result of a Mental and Nervous Disorder.

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person Person's immediate family.

REPATRIATION means Your transportation by air and/or surface transportation with a qualified medical attendant to Your Home County.

SICKNESS means sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

SOUND, NATURAL TEETH means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

TREATMENT means a specific in-office or Hospital physical examination of or care rendered to You, consultation, diagnostic procedures and services, Surgery, medical services and supplies including medication prescribed or provided by a Service Provider.

USUAL, REASONABLE and CUSTOMARY In relation to a charge, the most common charge for similar services, medicines or supplies within the area in which the charge is incurred, so long as those charges are reasonable. What is defined as Usual, Reasonable and Customary charges will be determined by Us. In determining whether a charge is Usual, Reasonable and Customary, We will act reasonably and will have regard to the following factors: the level of skill, extent of training, and experience required to perform the procedure or service; the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services; the severity or nature of the Sickness or Injury being treated; the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country; the cost to the provider of providing the service, medicine or supply; such other factors as We in the reasonable exercise of discretion, determine are appropriate.

YOU, YOUR, MEMBER or **INSURED PERSON** shall mean Insured Person.

WE, US or THE COMPANY means the Dale Underwriting Partners

POLICY BENEFITS

MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS

Benefits are payable for Covered Medical Expenses (see "Definitions") that are Usual, Reasonable and Customary less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.
No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations."

If a benefit is designated, Covered Medical Expenses include:
1. **Room and Board Expense:** 1) daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged by the Hospital.
2. **Intensive Care:** If provided in the Schedule of Benefits.
3. **Hospital Miscellaneous Expenses:** 1) while Hospital Confined; or 2) as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
4. **Routine Newborn Care:** 1) while Hospital Confined; and 2) routine nursery care provided immediately after birth. The benefits and the maximum amounts are specified in the Schedule of Benefits.
5. **Physiotherapy (Inpatient):** See Schedule of Benefits.
6. **Surgery:** Physician's fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed the benefit for the one of such procedures for which the largest benefit is payable.
7. **Assistant Surgeon Fees:** in connection with inpatient surgery, if provided in the Schedule of Benefits.
8. **Anaesthetist Services:** professional services administered in connection with inpatient surgery.
9. **Registered Nurse's Services:** 1) private duty nursing care only; 2) while Hospital Confined; 3) ordered by a licensed Physician; and 4) Medical Necessary. General nursing care provided by the Hospital is not covered under this benefit.
10. **Physician's Visits:** when Hospital Confined. Benefits are limited to one visit per day. Benefits do not apply when related to surgery. Covered Medical Expenses will be paid under the inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.
11. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. This benefit is payable within 3 working days prior to admission.
12. **Psychotherapy (Inpatient):** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits. Benefits are limited to one visit per day.
13. **Surgery (Outpatient):** Physician's fees for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed the benefit for the one of such procedures for which the largest benefit is payable.
14. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma centre; Physician's office; or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anaesthesia; drugs or medicines; therapeutic services; and supplies.
15. **Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.
16. **Anaesthetist (Outpatient):** professional services administered in connection with outpatient surgery.
17. **Outpatient Miscellaneous Benefit:** outpatient Hospital and Physician services. Outpatient services payable under this benefit will be designated "Paid under Outpatient Miscellaneous Benefit" in the Schedule of Benefits.
18. **Physician's Visits (Outpatient):** benefits are limited to one visit per day. Benefits do not apply when related to surgery or Physiotherapy. Covered Medical Expenses will be paid under the outpatient benefit or under the inpatient benefit for Physician's Visits, but not both on the same day.
19. **Physiotherapy (Outpatient):** benefits are limited to one visit per day. See benefit chart for additional conditions.

20. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the Use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.
21. **Diagnostic X-ray Services (Outpatient):** if so noted in the Schedule of Benefits, separate maximums apply to positive and negative X-rays. Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.
22. **Radiation Therapy (Outpatient):** See Schedule of Benefits.
23. **Laboratory Procedures (Outpatient):** Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.
24. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures.
25. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement.
26. **Chemotherapy (Outpatient):** See Schedule of Benefits.
27. **Prescription Drugs (Outpatient):** See Schedule of Benefits.
28. **Psychotherapy (Outpatient):** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits. Benefits are limited to one visit per day.
29. **Ambulance Services:** See Schedule of Benefits.
30. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Replacements are never covered. Durable medical equipment includes equipment that: 1) is primarily and customarily Used to serve a medical purpose; 2) can withstand repeated Use; and 3) generally is not Useful to a person in the absence of Injury or Sickness. No benefits will be paid for rental charges in excess of purchase price.
31. **Consultant Physician Fees:** when requested and approved by the attending Physician. Covered Medical Expenses will be paid under this benefit or under the Physician's Visits benefit, but not both on the same day.
32. **Dental Treatment:** 1) performed by a Physician; and, 2) made necessary by Injury to Sound, Natural Teeth. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.
33. **Maternity:** Same as any other Sickness.
34. **Complications of Pregnancy:** Same as any other Sickness.
35. **Supplemental Injury Benefit:** for treatment rendered: 1) on an inpatient or outpatient basis; 2) in a Physician's office or Hospital; and 3) as a result of Injury. This benefit will be paid prior to all other Basic benefits.
36.**Chemical Dependency:** Coverage for Medically Necessary treatment and supporting services for a Covered Person in an approved chemical dependency treatment program. The benefit is limited to $15,500.These limits do not apply to Medically Necessary detoxification provided in a Hospital unless the Covered person is currently enrolled in a chemical dependency treatment program.

The Covered Person is required to provide an initial assessment of the need for chemical dependency treatment and a treatment plan prior to scheduled treatment at his own expense between 10 and 30 working days before treatment is to begin:
a. If the Covered Person is ordered by a court of competent jurisdiction to undergo a chemical dependency assessment or treatment;
b. In a situation where the need for such treatment is related to deferral of prosecution, deferral of sentencing or suspended sentencing; or
c. In a situations pertaining to motor vehicle driving rights.

For the initial assessment the Covered Person may choose any individual that is (1) certified as a chemical dependency professional; and (2) employed by an approved treatment program.
Extension of Benefits:
Your coverage will be extended if You are Hospital confined for a Covered Injury and under the care of a Physician on the termination date of Your Period of Coverage. Coverage will terminate on the earlier of the following:

1) 30 days from the end of You Period of Coverage; or
2) The maximum benefit has been paid; or
3) Your release from the hospital or Physician care.

Deductible
The $250 deductible is the dollar amount of covered expenses which must be incurred as an our-of-pocket expense per injury or Sickness, for any one disablement.

An additional co-pay of $150 will be applied to Emergency Room visits. This co-pay is waived if the Insured Person is admitted to the hospital

MANDATED BENEFITS

BENEFITS FOR TEMPOROMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR DISORDER

Benefits shall be provided, on the same basis as benefits for treatment to any other joint in the body, for diagnostic and surgical treatment of temporomandibular joint disorder and craniomandibular disorder. Treatment may be administered or prescribed by a Physician or dentist. This coverage will not exceed a $5,000.00 maximum lifetime benefit.
Benefits shall be subject to all Deductible, co-payment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY FOLLOWING MASTECTOMY

Benefits will be paid the same as any other Sickness for all stages of reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications of mastectomy, including lymphedema in a manner determined in consultation with the attending Physician and the Insured Person.
Benefits shall be subject to all Deductible, co-payment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR CHILD HEALTH ASSURANCE

The benefits applicable for Dependent children shall include coverage for Child Health Supervision Services from the moment of birth to 16 years of age.
"Child Health Supervision Services" means Physician-delivered or Physician-supervised services which shall include as the minimum benefit coverage for services delivered at the intervals and scope stated below:
Child Health Supervision Services shall include periodic visits which shall include a history, a physical examination, a developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Paediatric Health Care of the American Academy of Paediatrics. Minimum benefits are limited to one visit payable to one provider for all services provided at each visit.
Benefits shall not be subject to the Deductible, but are subject to all co-payment, coinsurance, limitations, or any other provisions of the policy.

EXCLUSIONS AND LIMITATIONS

Applicable to all Sections

WE WILL NOT PAY UNDER ANY CIRCUMSTANCES IF:

1 For a Pre-existing Medical Conditions as defined within the Policy wording unless the Insured person has been covered under this Policy for 1 year without having a reoccurrence of that condition.
2.For charges for treatment which are not Medically Necessary.
3.You do not act in a responsible way to protect Yourself and to avoid making a claim.
4. You do not do everything You can to reduce Your loss as much as possible.
5. Your claim arises from consequential loss of any kind.
6. At the time of purchasing the policy, You Were aware of something that would give rise to You making a claim under this policy.
7. Your claim is for a loss which is recoverable by compensation under any workers compensation or transport accident laws or by any government sponsored fund, plan, or medical benefit scheme, or any other similar type legislation required to be effected by or under a law or any other Insurance policy.
8 Your claim arises because You act illegally or break any government prohibition or regulation including visa requirements.
9 Your claim arises from being in control of a motor cycle without a current motorcycle licence valid for the country You are in or You are a passenger travelling on a motorcycle that is in the control of a person that does not hold a current motorcycle licence valid for the country You are in.
10 Your claim arises because You did not follow advice in the mass media of any government or other official body's warning against travel to a particular country or parts of a country due to a strike, riot, bad weather, or civil commotion
11 Your claim is in respect of travel booked or undertaken against the advice of any medical adviser.
12 Your claim arises directly or indirectly from any terminal Sickness that was diagnosed prior to the policy being issued.
13 Your claim involves the cost of medication in use before the Effective Date or the cost for maintaining a course of treatment You were on prior to the Effective Date.
14 Your claim arises from a nuclear reaction or contamination from nuclear Weapons or radioactivity.
15 Your claim arises from biological and or chemical materials, substances, compounds or the like Used directly or indirectly for the purpose to harm or to destroy human life and or create public fear.
16. You participate in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
17. Any consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to, or arising in connection with:
    a) war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war.
    b) mutiny, riot, strike, military or popular uprising insurrection, rebellion, revolution, military or Usurped power.
    c) acting on behalf of or in connection with any organization with activities directed towards the overthrow by force of the Government de jure or de facto or to the influencing of it by terrorism or violence.
    d) martial law or state of siege or any events or causes which determine the proclamation or maintenance of martial law or state of siege (hereinafter for the purposes of this Exclusion called the "Occurrences").

18 Your claim arises because You hunt, race (other than on foot), engage in skydiving, parachuting, hang gliding, glider flying, parasailing, sail planning, bungee jumping, mountaineering where ropes or guides are normally Used; racing by horse, motor vehicle or motorcycle, snowmobiling, motorcycle/motor scooter riding, water skiing, spelunking, open water sailing, play polo, or You participate in professional sport or Amateur Athletics (This exclusion does not apply to non-competitive, recreational or intramural activities), or arises because You dive underwater Using an artificial breathing apparatus unless PADI or NAUI certified or You Were diving under licensed instruction.
19 Your claim arises from flying other than as a passenger on a regularly scheduled flight of a commercial airline
20. Charges are provided at no cost to You;
21. Your charges are for treatment which exceeds Usual and Customary charges;
22. You charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes;
23. Your services, supplies or treatment, including any period of Hospital confinement, Were not recommended, approved and certified as Medically Necessary and reasonable by a Physician;
24. Your claim is for any emergency evacuation.
25. Your claims is not presented to the Company for payment within three (3) months of receiving treatment;
26. If Your claim is caused by, contributed to, or resulting from the use of medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person Person's Physician.
27. Any Inpatient Hospital treatments or care, Surgery or Surgical Procedure, computerized tomography (CAT Scan) and Magnetic Resonance Imaging (MRI) that have not been pre-authorized by the Medical Claims Management Company.
28. Expenses incurred while participating in an illegal act or committing or attempting to commit a felony

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to:

1. Acne; acupuncture; allergy, including allergy testing; except as specifically provided in the policy;
2. Autistic disease of childhood, hyperkinetic syndromes, milieu therapy, learning disabilities, behavioural problems, parent child problems, attention deficit disorder, conceptual handicap, developmental delay or disorder or mental retardation;
3. Birth control and/or contraceptives, oral or other, whether medication or device, regardless of intended Use;
4. Circumcision;
5. Congenital conditions, except as specifically provided for Newborn or Adopted Infants;
6. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy.
7. Removal of warts, non-malignant moles and lesions;
8. Dental treatment, except for damage to sound, natural teeth;
9. Elective Surgery or Elective Treatment;
10. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a disease process;
11. Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, Weak feet, chronic foot strain, and symptomatic complaints of the feet;
12. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
13. Hirsutism; alopecia;
14. Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) or a sexually transmitted disease.
15. Immunizations; preventive medicines or vaccines, except where required for treatment of a covered Injury;
16. Lipectomy;
17. Nasal and sinus surgery;
18. Organ transplants, including organ donation;
19. Outpatient Physiotherapy; except for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation;
20. Prescription Drugs, services or supplies as follows:
a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other nonmedical substances, regardless of intended Use;
b) c) Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
d) Drugs labelled, “Caution - limited by federal law to investigational Use” or experimental drugs;
e) Products Used for cosmetic purposes;
f) Drugs Used to treat or cure baldness; anabolic steroids Used for body building;
g) Anorectics - drugs Used for the purpose of Weight control;
h) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
i) Growth hormones; or
j) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
21. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
22. Routine Newborn Infant Care, Well-baby nursery and related Physician charges in excess of 48 hours for vaginal delivery or 96 hours for caesarean delivery;
23. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness, except as specifically provided in the policy;
24. Services provided normally without charge by the Health Service of the Participating Organisation; or services covered or provided by the student health fee;
25. Sleep disorders;
26. Intentionally self-inflicted Injury unless caused whilst insane, suffering from a recognised illness or whilst under the influence of alcohol or drugs;
27. Supplies, except as specifically provided in the policy;
28. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
29. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
30 Weight management, Weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat, and treatment of eating disorders such as bulimia and anorexia. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The 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 govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan.** The **Primary plan** must pay benefits according to its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan.** The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense.**

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. 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. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

   1. **Plan** includes: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
   2. **Plan** does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal 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. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan.**

   When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the **Total Allowable expense** for that claim. This means that when this **Plan** is **Secondary,** it must pay the amount which, when combined with what the **Primary plan** paid, totals 100% of the highest **Allowable expense.** In addition, if this **Plan** is **Secondary**, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the **Primary plan**) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an **Allowable expense** under this **Plan.** If this **Plan** is **Secondary,** it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

D. **Allowable expense** is a health care expense, including coinsurance and copayments, which is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense.**

The following are examples of expenses that are not **Allowable expenses**:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense,** unless one of the **Plans** provides coverage for private hospital room expenses.
2. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense.**
3. If a person is covered by two 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.**

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the **Plan,** and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the** parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans,** the rules for determining the order of benefit payments are as follows:

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan.**

B. (1) Except as provided in subsection (2), a **Plan** that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both **Plans** state that the complying plan is primary.
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the **Plan** provided by the contract holder. Examples include major medical coverages that are superimposed over 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 calculating payment of its benefits only when it is secondary to that other **Plan.**

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan.** 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, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan.**

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

   a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      - The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan;** or
      - If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan.**

   b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      i. If a court decree states that one of the parents is responsible for the dependent 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 commencing after the **Plan** is givennotice of the court decree;

ii. If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

iii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above determine the order of benefits;

iv. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection (a) above determine the order of benefits; or

v. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The **Plan** covering the **Custodial parent,** first;
- The **Plan** covering the spouse of the **Custodial parent,** second;
- The **Plan** covering the **non-custodial parent,** third; and then
- The **Plan** covering the spouse of the **non-custodial parent,** last

c. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of subsection (a) or (b) above determine the order of benefits as if those individuals were the parents of the child.

3. Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan.** The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan.** The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D (1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan,** the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan.** If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D (1) can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan.**

6. If the preceding rules do not determine the order of benefits, the **Allowable expenses** must be shared equally between the **Plans** meeting the definition of **Plan.** In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan.**

EFFECT ON THE BENEFITS OF THIS PLAN

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 the total **Allowable expenses.** In determining the amount to be paid for any claim, the **Secondary plan** must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total **Allowable expense** for that claim **Total Allowable expense** is the highest **Allowable expense** of the **Primary plan** or the **Secondary plan.** In addition, the **Secondary plan** must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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.** The Insurer or its designated representative 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. The Insurer or its designated representative need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Insurer or its designated representative any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

If payments that should have been made under **This plan** are made by another **Plan,** the issuer has the right, at its discretion, to remit to the other **Plan** the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other **Plan** are considered benefits paid under **This plan.** To the extent of such payments, the issuer is fully discharged from liability under **This plan.**

RIGHT OF RECOVERY

The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.