Bellevue College

2013-2014

Blanket Student Accident & Sickness Plan

For International Students

Firebird International Insurance Group, LLC

Rising Above and Beyond the Ordinary

HTH Worldwide

URGENT / PLEASE READ:

This medical booklet is a summary of the Master Certificate. It provides basic information related to the types of expenses you must pay for covered services before the benefits of this plan are provided. To prevent unexpected out-of-pocket expenses, it's important for you to understand what you're responsible for. To find out the specific dollar amounts of any applicable copayments, deductible, coinsurance and out-of-pocket maximum as well as when they apply, please see the Schedule of Benefits section.

For exact details, please refer to the Master Certificate in the Firebird website: www.fiig-insurance.com under your school name.

Any conflict in the interpretation of this booklet will be governed by the terms of the Master Certificate.

INTERNATIONAL STUDENT HEALTH PLAN

Promotion of good health for international students has always been our concern. This booklet summarizes how the Firebird International Student Health Insurance Plan works, what it covers and how the plan will help you with medical costs. After you've read about the Firebird International Student Health Insurance Plan, keep these important facts in mind:

- Keep your insurance card with you at all times, and show it to the doctor or hospital when you seek medical treatment or call for appointments.
- You may contact a Firebird representative 24 hours a day, 7 days a week at the phone number listed on your insurance id card or on the back of this booklet.
- You may choose any doctor you wish, but if you use a doctor in our PPO network, it may save you money.
- You can locate doctors and hospitals on the web by logging in at: **www.fiig-insurance.com** (see pgs.24 & 25).

WHO IS ELIGIBLE TO ENROLL

All full time: international students, visiting faculty, scholars or other persons possessing and maintaining a current passport and valid visa status (F-1, J-1, or M-1, etc.) engaged in educational activities at an institution of higher learning who are temporarily located outside their home country and have not been granted permanent residency status, can be insured under the Policy.

Inbound international students must meet the criteria established, published, and updated from time to time by the student and exchange visitor program administered by the Department of US Immigration and Customs Enforcement.

To be an Insured Person under the Policy the student must have paid the required premium. The Company maintains its right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is a pro-rata refund of premium.

Family Members You May Cover: If an eligible student enrolls for coverage, they may also enroll their eligible dependents in the same plan at the same time the student enrolls. DEPENDENTS MUST BE ENROLLED ON; the date the student is enrolled or within 31 days of birth, marriage, or upon arrival in the U.S. in order to qualify for coverage this policy year.

DEADLINES FOR ADDING A NEW CHILD TO YOUR COVERAGE

A child born to or adopted by you, your enrolled spouse or domestic partner, while you are enrolled in this policy will receive the same benefits as you for the first three weeks after birth.

If you want continuing coverage for your child after this, you must enroll your child in the timeframes listed below:

- You must enroll a newborn child and pay any additional premium to the Student Insurance Office **within 60 days** of birth
- For adoptions, notify the school of adoptions in writing, and pay any additional premium within 60 days of adoption. We cover adopted children from the date the child is placed for adoption only if you send us a written request to add the child no more than 60 days after the child is placed and include any additional premium.
- You must enroll eligible children acquired through marriage or domestic partner registration within 31 days of marriage or registration.

WHO IS ELIGIBLE TO ENROLL (cont'd)

An Eligible Dependent may be the Eligible Participant's partner and/or his/her unmarried dependent children under age 26. The attainment of age 26 shall 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 development disability or physical handicap and (2) chiefly dependent upon the Eligible Participant for support and maintenance, provided proof of such incapacity and dependency is furnished to the Insurer by the Eligible Participant within 31 days of the child's attainment of age 26.

The term "child/children" includes a natural child, a legally adopted child, a stepchild, and a child who is dependent on the Eligible Participant during any waiting period prior to finalization of the child's adoption. **Dependents must be enrolled for the same term of coverage for which the Insured Student enrolls. Dependent coverage expires concurrently with that of the Insured Student.**

Eligible Participant includes a student's spouse or registered domestic partner. For a domestic partner to be eligible for coverage, you and your domestic partner must be registered with the Washington State registry or jurisdiction where domestic partner registration is offered. You may be asked to submit a copy of your marriage certificate, the Washington State registration certificate or certificate from other jurisdiction where domestic partner registration is offered. **If you are unable to provide this documentation, your spouse or domestic partner will be deemed ineligible and their claims will be denied.**

WHEN COVERAGE STARTS

Provided the correct premium is received timely and the Eligible Participant and/or Eligible Dependent are properly enrolled, coverage will be effective:

1. On the first day of the school term for which coverage is applied for if the Eligible Participant became an Eligible Participant on the first day of the school term and applies within the first 60 days of the school term.

2. On the first day of becoming an Eligible Participant if such day is after the first day of the school term and enrollment is made within 60 days of becoming an Eligible Participant.

3. On the first day an Eligible Participant suffers an involuntary loss of other coverage if such day is after the first day of the school term, and enrollment is made within 60 days of such loss.

4. On the first day of the next school term if enrollment is made more than 60 days after becoming an Eligible Participant or after becoming an Eligible Dependent, or after an Eligible Participant or an Eligible Dependent suffers an involuntary loss of other coverage.

5. For an Eligible Dependent child, on the date of birth, adoption or Placement for Adoption, if enrollment is made within 60 days of such event.

6. For an Eligible Dependent, on the first day of the first month following the Dependent's initial eligibility date for dependents joining an Insured Participant's family through marriage or other court decree while the Insured student is covered under the Policy.

7. For an Eligible Dependent, on the first day of the first month following the date the Dependent first meets the definition of "Eligible Dependent" if such Dependent did not qualify at the time the Insured Participant was enrolled under the Policy. Enrollment must be made within 31 days of becoming eligible.

8. For an Eligible Dependent, on the first day of the first month an Eligible Dependent suffers an involuntary loss of other coverage if such day is after the first day of the school term, and enrollment is made within 31 days of such loss;

For purposes of Item 1. above, eligible students taking a term or semester break (herein referred to as "term break"), annually, in accordance with school policy and while keeping coverage in force are considered Eligible Participants engaged in full-time educational activities. For schools with a two-semester term system, summer break is the designated term break. For schools with a trimester or quarter term system, any trimester or quarter can be taken as the term break, provided only one trimester or quarter is taken per academic calendar year.
Dependent coverage cannot become effective prior to the effective date of the Eligible Participant's coverage.

EXTENDED COVERAGE PROVISION

Provided the correct premium is received timely and the Eligible Participant and/or Eligible Dependent are properly enrolled, new F-1 visa Participants and their Eligible Dependents will be eligible for coverage for up to 30 days prior to the start of classes and/or 30 days after graduation or completion of an educational program, provided that the Insured Participant is on the Policyholder's I-20 form and the Insured Participant and their Eligible Dependents are located in the United States.

WHEN COVERAGE ENDS

Coverage will automatically terminate on the earliest of:

1. The date the Policy terminates;

2. The last day of the period for which premium has been timely paid according to Policy provisions;

3. The date the Insured Individual is no longer eligible for coverage;

4. For an Insured Individual under Extended Coverage, upon the Eligible Students graduation or completion of an educational program and in preparation for the resulting departure from the United States, coverage will terminate 30 days following graduation or completion of an educational program, provided the student and his or her covered Dependents remain in the United States during that 30-day period.

5. The date requested by the Insured Individual approved by the Policyholder in writing that is no sooner than 5 days after the date the Company or its authorized administrator receives written notice;

6. The date the Insured Individual departs the United States for the Students home country or country of regular domicile.

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

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

At the end of any Period of Coverage an Eligible Participant may re-enroll by completing an enrollment form and paying any required premium.

EXTENSION OF BENEFITS AFTER TERMINATION

If you or your covered family member is in the hospital on the termination date due to a covered injury for which benefits were paid before the termination date, covered medical expenses for that injury will continue to be paid as long as the condition continues, for up to a maximum of 90 days after the termination date, subject to the payment of premium for the period of coverage and subject to the maximum benefit. Such benefits terminate if the Insured Individual becomes covered for the Accident or Sickness, for which benefits were continued, under any other medical coverage.

EXCESS COVERAGE

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one **Plan.** 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.** For more information on COB (Coordination of Benefits), please refer to the Master Certificate, Section 13, page 31.

PRE-EXISTING CONDITION LIMITATION

This plan has a waiting period for pre-existing conditions for members who are 19 or older. A pre-existing condition is a medical condition that existed prior to the beginning of your coverage. It is defined as:

- The existence of symptoms within the 3 months immediately prior to your effective date under the plan, or
- Any condition that is diagnosed, treated or recommended for treatment within the 3 months immediately prior to your effective date.

Pre-existing conditions will not be covered for the first three months of coverage under the plan, unless you were insured under another similar health coverage for at least three months immediately before becoming insured under this coverage.

Credit will be given for the period of time you were covered under the immediately preceding health coverage if it was less than three months.

The pre-existing condition limitation may not apply in full or in part if you had "creditable coverage" (coverage under another similar health coverage) in the 3 months prior to your effective date of coverage in this coverage.

Any lapse in coverage means you will have to satisfy the pre-existing condition waiting period again. For example, if you do not enroll for a quarter, then re-enroll the following quarter, the pre-existing condition waiting period will have to be satisfied again.

If a claim was paid that was related to a pre-existing condition, payment will not constitute a waiver of this exclusion for that claim or for any subsequent claim if it is later determined that the condition was pre-existing.

EXCEPTIONS

The pre-existing condition exclusion does not apply to any of the following:

- Medically necessary abortion
- Pregnancy, including complications, if such condition is covered under this plan
- Expenses incurred for the cost of Low Protein Modified Food Products for Covered Persons inflicted with phenylketonuria (PKU)
- To the Medical Evacuation Benefit, Repatriation of Remains or to the Bedside Visit Benefit.

Genetic information will not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such information. (Genetic testing is not covered under the plan.)
If a claim was paid that was related to a pre-existing condition, payment will not constitute a waiver of this exclusion for that claim or for any subsequent claim if we later determine that the condition was pre-existing.

SCHEDULE OF BENEFITS

All benefits and limits are stated per Covered Person per plan year.

BENEFITS	NETWORK PROVIDER	NON-NETWORK PROVIDER
Maximum Benefit per Condition	$500,000 per plan year	
Deductible (per participant)	$0	
Coinsurance	Plan pays 100%* You pay 0%	Plan pays 90%** You pay the other 10%
Coinsurance Maximum (per participant per plan year)	$1,000	
INPATIENT EXPENSES		
Inpatient Hospital/Surgical (all covered medical expenses associated with inpatient hospitalization and surgery)	You pay a $50 copay per admission, then the plan pays 100%*	You pay a $50 copay per admission, then the plan pays 90%**
OUTPATIENT EXPENSES		
Outpatient Hospital/Surgical (all covered medical expenses associated with outpatient services and surgery)	You pay a $50 copay, then the plan pays 100%*	You pay a $50 copay, then the plan pays 90%**
EMERGENCY SERVICES		
Emergency Room Services	You pay a $50 copay, then the plan pays 100%*	You pay a $50 copay, then the plan pays 100%**
Ambulance	Plan pays 100%* You pay 0%	Plan pays 100%* You pay 0%
PREVENTIVE CARE HIGHLIGHTS		
Benefits for preventive care that meet the federal guidelines are not subject to any deductible, copay or coinsurance when you use a Network Provider. Expenses are covered at 100% of allowable charges. ***See the Description of Coverages, Medical Expenses for more information.***		
Preventive Care Benefits for preventive care that meet the federal guidelines aren't subject to any deductible, copay or coinsurance when you use a Network Provider. Please see the Preventive Care benefit for detail.	Plan pays 100%* You pay 0%	You pay a $15 copay, then the plan pays 90%**
ADDITIONAL EXPENSES		
Physician Office Visits (services like diagnostic x-ray, laboratory tests and rehabilitation therapy) For preventive care, see the Preventive Care Highlights	You pay a $15 copay, then the plan pays 100%*	You pay a $15 copay, then the plan pays 90%**
Outpatient prescription drugs	You pay a 50% copay of the actual cost of the drug. The plan pays 50% of the actual cost. Birth Control pills are covered. When you get birth control from a pharmacy you don't pay any deductible, copay or coinsurance. See the Preventive Care benefit for details. Your costs are always lowest for generic drugs than brand-name drugs. Certain drugs are not covered, including: drugs used for cosmetic purposes, investigational or experimental drugs, diet drugs, fertility drugs, anabolic steroids used for body building, or growth hormones. See the General Policy Exclusions section for a full list of excluded drugs and other details.	
Abortion	Paid as any other sickness	Paid as any other sickness
Alcoholism/Chemical Dependency Treatment	Paid as any other sickness	Paid as any other sickness

BENEFITS	NETWORK PROVIDER	NON-NETWORK PROVIDER
Braces, Appliances and Durable Medical Equipment	100% of allowable expenses	
Complications of Pregnancy	Paid as any other sickness	Paid as any other sickness
Diabetic Treatment and Equipment Services that meet the federal guidelines aren't subject to any deductible, copay or coinsurance when you use a Network Provider. See the Preventive Care benefit.	Paid as any other sickness	Paid as any other sickness
Diabetic Supplies	See above Outpatient Prescription Drug Coverage	See above Outpatient Prescription Drug Coverage
Home Health Care (maximum of 130 visits/plan year)	Paid as any other sickness	Paid as any other sickness
Hospice (maximum of 6 months per lifetime)	Paid as any other sickness	Paid as any other sickness
Infusion Therapy	Paid as any other sickness	Paid as any other sickness
Injury to Teeth	100% of allowable expenses up to $1,000 dental maximum per injury	
Mammography Services that meet the federal guidelines aren't subject to any deductible, copay or coinsurance when you use, or care is coordinated through, Student Health Center. See the Preventive Care benefit.	Paid as any other sickness	Paid as any other sickness
Maternity	Paid as any other sickness	Paid as any other sickness
Mental Health – Inpatient	Paid as any other sickness	Paid as any other sickness
Mental Health – Outpatient	You pay a $15 copay, then the plan pays 100%*	You pay a $15 copay, then the plan pays 90%**
Neurodevelopmental Therapy	Paid as any other sickness	Paid as any other sickness
Phenylketonuria Treatment	Paid as any other sickness	Paid as any other sickness
Reconstructive Breast Surgery (post mastectomy)	Paid as any other sickness	Paid as any other sickness
Skilled Nursing Facility (maximum of 90 days/plan year)	Paid as any other sickness	Paid as any other sickness
Sterilization Services that meet the federal guidelines aren't subject to any deductible, copay or coinsurance when you use a Network Provider.	Paid as any other sickness	Paid as any other sickness
Temporomandibular Joint Dysfunction and Related Disorders	Paid as any other sickness	Paid as any other sickness
Transplants	Paid as any other sickness	Paid as any other sickness
ADDITIONAL COVERAGES		
Accidental Death & Dismemberment	Maximum Benefit: Principal Sum - Eligible Participant: up to $10,000 Partner: up to $5,000 Child: up to $5,000	
Medical Evacuation	Maximum Benefit up to $50,000	
Bedside Visit	Up to a maximum benefit of $1,000 for the cost of one economy round-trip air fare ticket to, andthe hotel accommodations in, the place of the Hospital Confinement for one (1) person	
Repatriation of Remains	Maximum Benefit up to $50,000	

* Of the allowable charge
** Non-network benefits (non-network providers) are limited to allowable charges. In addition to your percentage of the coinsurance, you are responsible for all amounts that exceed the allowable charges.

DESCRIPTION OF COVERAGES

MEDICAL EXPENSES

WHAT'S COVERED

Preventive Care : What Are Preventive Services?

Preventive services are now defined as follows:

- Evidence-based items or services with a rating of "A" or "B" in the current recommendations of the U.S. Preventive Task Force (USPSTF). Also included are additional preventive care and screenings for women not described above in this paragraph as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC) and Prevention.
- Evidence-informed infant, child and adolescent preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
- Women's preventive care, as defined by regulation for women's health.

A full list of these preventive services is available by calling Customer Service. The list also provides the guidelines on how often the services should be provided and who should receive them. **Not all services recommended or billed by your doctor as part of your routine physical may comply with these guidelines. The list and guidelines are subject to change as required by law and regulation.**

Benefits for preventive care that meet the federal guidelines aren't subject to any deductible, copay or coinsurance when you use a Network Provider. Please see the Schedule of Benefits for how Non-Network Provider preventive care provided at other locations is covered. Non-preventive services are covered the same as any other service. Please see the Schedule of Benefits.

Exams and Screening

Benefits include:

- Routine physical exams
- Well-baby and well-child exams
- Physical exams related to school, sports and employment
- Preventive diagnostic services
- Screening mammograms
- Healthy eating assessments and nutritional counseling.

Health Education

Examples of covered health education services are asthma education, pain management, childbirth and newborn parenting training and lactation.

Diabetes Health Education

Benefits are provided for outpatient health education and training services to manage the condition of diabetes.

Contraceptive Management

Benefits include:

- Office visits and consultations related to contraception
- Injectable contraceptives and related services
- Implantable contraceptives (including hormonal implants) and related services
- Emergency contraception methods (oral or injectable)

Sterilization procedures

Sterilization procedures for men and women are covered as preventive. However, when sterilization is performed as the secondary procedure, associated services such as anesthesia and facility expenses will be subject to your deductible and coinsurance and will not be reimbursed under this benefit. Please see the Schedule of Benefits.

Women's Preventive Care

Benefits include:

- All FDA approved Contraceptive drugs, devices and supplies
- Breast feeding counseling
- Maternity diagnostic screening (including screening for gestational diabetes)
- Counseling for sexually transmitted infections.

Breast Pumps

Standard Electric breast pumps are covered only when provided by a medical equipment supplier or a provider approved by us. Please see the definitions of Provider. Rental of hospital grade breast pumps are only covered when medically necessary.

The Preventive Care benefit DOES NOT cover:

- Charges for preventive services that exceed what's covered under this benefit
- Charges for preventive services or items that don't meet the federal guidelines for preventive services described at the start of this benefit, except as required by law. This includes services or items provided more often than as stated in the guidelines or to patients who are not in the population targeted by the guidelines.
- Hysterectomy. (Covered on the same basis as other surgeries).
- Inpatient routine newborn exams while the child is in the hospital following birth. These services are covered under the Newborn Care benefit.
- Non-prescription contraceptive drugs, supplies or devices (except emergency contraceptive methods)
- Routine or other dental care
- Routine vision and hearing exams
- Physical exams for basic life or disability insurance
- Services that are related to a specific illness, injury or definitive set of symptoms exhibited by the member.
- Sterilization reversal
- Testing, diagnosis, and treatment of infertility, including fertility enhancement services, procedures, supplies and drugs
- Work-related or medical disability evaluations

ADDITIONAL MEDICAL EXPENSES

WHAT'S COVERED

Inpatient Expenses

The plan covers these charges subject to all deductibles, copayment, coinsurance, limitations, or any other provisions of the plan, including but not limited to the maximum benefit of $500,000 per condition.

Benefits include:

- Hospital room and board
- Consultant physician fees
- Miscellaneous hospital expense
- In-hospital doctor visit and medical expense
- Surgery
- Anesthetist
- Assistant surgeon
- Multiple surgical procedure expense.

ADDITIONAL MEDICAL EXPENSES cont'd

Outpatient Expenses

The plan covers these charges subject to all deductibles, copayment, coinsurance, limitations, or any other provisions of the plan, including but not limited to the maximum benefit of $500,000 per condition.

Benefits include:

- Hospital outpatient department and other services
- Emergency room, is subject to the copayment as shown in the Schedule of Benefits per visit
- Clinical lab
- Radiological lab or other similar facility licensed by the state
- An Ambulatory Surgical Center for covered surgery
- Anesthetist
- Assistant surgeon
- Consultant physician fees
- Surgery
- Multiple surgical procedure expense
- Blood-borne pathogen protocol
- Home phototherapy: the services and supplies furnished by an approved home phototherapy provider will be covered for newborn hyperbilirubinemia
- Radiation therapy, kidney dialysis, inhalation therapy
- Chemotherapy
- Surgical dressings, splints, casts, and other devices used to correct fractures and dislocations.

MATERNITY

The plan will pay benefits for the insured student and their spouse or domestic partner's medically necessary maternity care, including hospital, surgical and medical care. The plan also covers charges for midwifery and birth center expenses. **Maternity care benefits are not covered for enrolled dependent children.** However, benefits are provided for complications of pregnancy on the same basis as any other condition for **all insured persons**. Benefits are subject to all deductibles, copayment, coinsurance, limitations, or any other provisions of the plan, including but not limited to the maximum benefit of $500,000 per condition.

The plan will cover the first two ultrasounds per pregnancy. Additional ultrasounds will be covered if medically necessary. The plan covers charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a health care facility, unless the attending physician in consultation with the mother, makes an alternative decision on the length of inpatient stay. The decision must be based on accepted medical practice. For a mother and newborn child who remain in the hospital for the minimum length of time stated above, the plan will pay for post-delivery care as ordered by the attending physician, in consultation with the mother. For a mother and newborn child, at the time of discharge, the attending physician in consultation with the mother will make a determination of the type and location of follow-up care based on accepted medical practice, including in-person care, services of a midwife and home health care.

The plan also covers routine nursery care furnished to a baby after its birth and routine well-baby examination by a physician furnished to the baby before the participant mother is discharged from the hospital. In addition, the newborn child will have the same coverage as the participant for the first three weeks after birth.

GENERAL POLICY EXCLUSIONS

Here is a list of services the plan does not cover. No Benefits will be paid for services or supplies for treatment for or related to, contributed to, or resulting from the following:

1. Acupuncture services, supplies and/or treatment that is not prescribed to treat a covered injury or illness.

2. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline

3. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this plan or for newborn or adopted children

4. Surgery for the correction of refractive error and services and prescriptions for eye examinations, eye glasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury.

5. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extractions of teeth, or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia, except as provided herein for repairs to sound natural teeth required due to injury.

6. Community wellness classes and programs that promote positive health and lifestyle choices. Examples of these classes and programs are adult, child, and infant CPR, safety, babysitting skills, back pain prevention, stress management, bicycle safety and parenting skills, except for services that meet the standards for preventive medical services in the Preventive Care benefit.

7. Counseling, education or training services, except as stated under the Alcoholism/Chemical Dependency Treatment, Diabetes Treatment benefit, Mental Health benefit, or for services that meet the standards for preventive medical services in the Preventive Care benefit. This includes vocational assistance and outreach; social, sexual and fitness counseling; and caffeine dependency. Also not covered is family and marital psychotherapy or counseling, except when medically necessary to treat the diagnosed mental or substance use disorder or disorders of a member.

8. Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations thereof. However, this exclusion doesn't apply to treatment of neurodevelopmental disabilities in children age 6 and under as stated under the Neurodevelopmental Therapy benefit.

9. Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy.

10. Nonmedical services, such as spiritual, bereavement, legal or financial counseling

11. Recreational, vocational, or educational therapy; exercise or maintenance-level programs; social or cultural therapy; gym or swim therapy

12. Custodial care: care provided in rest homes, health resorts, homes for the aged, halfway houses or places mainly for domiciliary or custodial care; extended care in treatment or substance abuse facilities for domiciliary or custodial care

GENERAL POLICY EXCLUSIONS-cont'd

13. Genetic testing

14. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear that does or can impair normal hearing, apart from the disease process

15. Human growth hormone

16. Preventive medicines, except as required by law

17. Injury or sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation

18. Injury sustained while participating in any professional or intercollegiate sport, contest or competition; traveling to or from such sport, contest or competition as a participant; or while participating in any practice or conditioning program for such sport, contest or competition

19. Learning disabilities (excluding ADD/ADHD) and behavioral problems, services and supplies

20. Naturopathic services

21. On-Line or Telephone Consultations. Electronic, on-line, internet or telephone medical consultations or evaluations

22. Orthotics (except for diabetes treatment)

23. Over-the-counter drugs and take-home medications, except as required by law

24. Participation in a riot or civil disorder; commission of or attempt to commit a felony

25. Prescription drug, services or supplies as follows:

a. Products used for cosmetic purposes

b. Drugs labeled "Caution – limited by federal law for investigational use" or experimental drugs

c. Drugs used to treat or cure baldness

d. Anabolic steroids used for body building

e. Anorectics – drugs used for the purpose of weight control

f. Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene or Viagra

g. Growth hormones

h. Refills in excess of the number specified or dispensed after one (1) year of the date of the prescription.

26. Prosthetic appliances and orthotic devices, except as specifically provided in the plan

GENERAL POLICY EXCLUSIONS-cont'd

27. Reproductive/infertility services including but not limited to: fertility tests; infertility for male/female including any services or supplies rendered for the purpose or with the intent of inducing conception. Examples of fertilization procedures are: ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance your reproductive ability; impotence, organic or otherwise; reversal of sterilization procedures.

28. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study

29. Routine or preventive care that doesn't meet the federal guidelines for preventive services described in the Preventive Care benefit. This includes services or items provided more often than stated in the guidelines. Routine or palliative foot care, including hygienic care; impression casting for foot prosthetics or appliances and prescriptions thereof; fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other symptomatic foot problems. However, foot-support supplies, devices and shoes are covered for the treatment of diabetes.

30. Sexual dysfunction services, surgery or related expenses or supplies

31. Expenses incurred for, or related to sex change surgery or to any treatment of gender identity disorders.

32. Services and/or supplies that are not medically necessary

33. Services or supplies that you furnish to yourself or that are furnished to you by a provider who is an immediate relative. Immediate relative is defined as spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent or spouse of grandchild.

34. Services provided normally without charge by the health service of the policyholder or services covered or provided by the student health fee

35. Treatment in a governmental Hospital unless there is a legal obligation for the participant to pay for such treatment

36. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered)

37. Weight management services and supplies related to weight reduction programs, weight management programs, related nutritional supplies, surgery or treatment for obesity, surgery for removal of excess skin or fat.

38. Resulting from a motor vehicle accident if an Insured Individual was operating the vehicle without a valid driver's license in the state where the Insured Individual primarily resides while attending school;

39. Under the Accidental Death and Dismemberment provision, for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.

DEFINITIONS

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

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

Affordable Care Act: The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

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.

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

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

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

Covered Charge or Covered Medical Expense
Are reasonable charges that are:

- Not in excess of the allowable charge
- Not in excess of the maximum benefit amount payable per service as specified
- Made for services and supplies not excluded under the plan
- Made for services and supplies which are a Medical Necessity
- Made for services included in the plan
- In excess of the amount stated as a deductible, if any.

DEFINITIONS cont'd.

Covered Services
Are an expense actually incurred by or on behalf of a Covered Person for those services and supplies which are:

- administered or ordered by a Physician;
- Medically Necessary to the diagnosis and treatment of an Injury or Sickness;
- are not excluded by any provision of the Policy; and incurred while the Covered Person's insurance is in force under the Policy, except as stated in the Extension of Benefits provision. A Covered Medical Expense is deemed to be incurred on the date such service or supply which gave rise to the expense or charge was rendered or obtained.

Emergency Care
A medical screening examination to evaluate a medical emergency that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department.

Further medical examination and treatment to stabilize the member to the extent the services are within the capabilities of the hospital staff and facilities or, if necessary, to make an appropriate transfer to another medical facility. "Stabilize" means to provide such medical treatment of the medical emergency as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the member from a medical facility.

Essential Health Benefits
Benefits defined by the Secretary of Health and Human Services that shall include at least the following general categories: ambulatory patient services, emergency care, hospitalization, maternity and newborn care, mental health and chemical dependency services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. The designation of benefits as essential shall be consistent with the requirements and limitations set forth under the Affordable Care Act and applicable regulations as determined by the Secretary of Health and Human Services.

Hospital
A licensed or properly accredited general hospital which:

- Is open at all times
- Is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients
- Is under the supervision of a staff of one or more legally qualified physicians available at all times
- Continuously provides on the premises 24-hour nursing service by Registered Nurses
- Provides organized facilities for diagnosis and major surgery on the premises, and
- Is not primarily a clinic, nursing, rest or convalescent home, or an institution specializing in or primarily treating mental disorders.

Home Health Care and Hospice Care
Benefits will be provided on the same basis as any other sickness or injury for home health care and hospice care for you if you were homebound and would otherwise require hospitalization. Benefits will consist of services rendered by home health and hospice agencies licensed by the Department of Social and Health Services when recommended by a Physician.

Home health care coverage will provide benefits for a maximum of 130 health care visits per plan year. Hospice care coverage will provide benefits for terminally ill patients for a period of care of not more than six months. Limited extensions will be granted if you are facing imminent death as certified in writing by the attending physician.

Injury
A Bodily injury that is:

- Directly and independently caused by specific accidental contact with another body or object
- Unrelated to any pathological, functional, or structural disorder
- A source of loss
- Treated by a Physician within one year after the date of accident, and
- Sustained while you are covered under this plan.

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 plan's effective date will be considered a sickness under this plan.

Inpatient
Means a person confined in a Hospital for at least 18 hours and charged room and board.

Insurer
BCS Insurance Company

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy
Means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

Maximum per Condition
Means the total amount of benefits payable for each injury or sickness under this plan.

Medically Necessary
Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Mental health services
Means medically necessary inpatient and outpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, with the exception of the following categories, codes and services:

- Substance related disorders;
- Life transition problems, currently referred to as "v" codes, and diagnostic codes 302 through 302.9 as found in the Diagnostic and Statistical Manual of Mental Disorders (DSM), 4th edition, published by the American Psychiatric Association; and
- Skilled nursing facility services, home health care, residential treatment, and custodial care.

Network Providers
Healthcare providers that have a contractual arrangement with Aetna Passport.

Non-Network Providers
Healthcare providers that do not have a contractual arrangement with Aetna Passport.

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

Participating Institution
Means the college, school or other institution of learning which has elected that its Eligible Participants and, if applicable, the dependents of those Eligible Participants be covered under the Policy and which has been accepted by the Insurer for coverage under the Policy.

Physician—A state-licensed:

- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy (D.O.).

In addition, professional services provided by one of the following types of providers will be covered under this plan, but only when the provider is providing a service within the scope of his or her state license; providing a service or supply for which benefits are specified in this plan; and providing a service for which benefits would be payable if the service were provided by a physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Denturist
- Midwife
- Optometrist (O.D.)
- Physician Assistant
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Nurse (A.R.N.P.), (N.P.)(R.N.) (L.P.N.) licensed in Washington state.
- Physical, Occupational or Speech Therapist
- Certified social worker or counselor

Care must be provided to an insured person, other than a member of the Physician's immediate family. The term "member of the immediate family" means any person related to an insured person's within the third degree by the laws of consanguinity or affinity.

Prescription Drugs:
Prescription drugs include the following:

- Prescription legend drugs
- Compound medications when at least one ingredient is a prescription legend drug
- Any drugs which may dispensed under federal law by written prescription
- Injectable insulin.

Rehabilitation Therapy
Means medically necessary treatments provided to either 1) restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an injury, illness or surgery; or 2) treat disorders caused by physical congenital anomalies. Services must be furnished and billed by a hospital, rehabilitation facility, physician, physical, occupational, or speech therapist, chiropractor, or massage therapist. Services must be referred by the attending physician. After 12 visits a medical review may be requested to ensure additional sessions are medically necessary.

Sickness
A sickness, illness or disease that causes loss, and originates while the insured person is covered under this plan. All related conditions and recurrent symptoms of the same or similar condition will be considered one sickness. Covered medical expenses incurred as a result of an Injury that occurred prior to this plan's effective date will be considered a sickness under this plan.

Sterilization
The plan covers charges for sterilization procedures. But, the plan does not cover charges for the reversal of a sterilization procedure. Services that meet the federal guidelines aren't subject to any deductible, copay or coinsurance. See the Preventive Care benefit.

Temporomandibular Joint Dysfunction and Related Disorders
Benefits for all of the Covered Services previously described in this Certificate are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

Total Disability or Totally Disabled

1. With respect to a Covered Person who otherwise would be employed, Total Disability or Totally Disabled means the Covered Person's complete inability to perform all the substantial and material duties of his/her regular occupation while under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability.

2. With respect to a Covered Person who would not otherwise be employed, Total Disability or Totally Disabled means the Covered Person's inability to engage in the normal activities of a person of like age and sex while:

a. Under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability, or

b. Hospital Confined or home confined at the direction of his/her Physician due to Injury or Sickness, except for trips away from home to receive medical treatment.

Transplants
The plan covers charges the same as for any other sickness for Medically Necessary services and supplies after meeting the pre-existing condition requirements relating to the following eligible organ transplants:

- Heart
- Heart/lung combined
- Kidney
- Kidney/pancreas
- Lungs – single/bilateral
- Liver
- Cornea
- Bone marrow or other form of stem cell rescue
- The plan does not cover any donor expenses.

GLOBAL ASSISTANCE SERVICES

All Eligible Participants are entitled to Global Assistance Services while traveling outside of the United States. In the event of an emergency, they should go immediately to the nearest physician or hospital without delay and then contact HTH Worldwide. HTH Worldwide will then take the appropriate action to assist and monitor the medical care until the situation is resolved. To contact HTH Worldwide in the event of an emergency, call 1.800.257.4823 or collect to +1.610.254.8771.

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

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

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

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

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

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

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

GLOBAL ASSISTANCE SERVICES cont'd.

Repatriation of Remains Benefit: If a Covered Person dies while traveling or living outside of his/her home country during the Period of Coverage, the Insurer will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Schedule of Benefits, for the preparation of the body for burial, or the cremation, and for the transportation of the remains to his/her Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body, urns, caskets, coffins, visitation, burial or funeral expenses. Any expense for repatriation of remains requires approval in advance by the Plan Administrator.

No benefit is payable if the death occurs after the Termination Date of the Plan. However, if the Covered Person is Hospital Confined on the Termination Date, eligibility for this benefit continues until the earlier of the date the Covered Person's Confinement ends or 31 days after the Termination Date. The Insurer will not pay any claims under this provision unless the expense has been approved by the Plan Administrator before the body is prepared for transportation.

Bedside Visit Benefit: If a Covered Person is Hospital Confined due to an Injury or Sickness for more than 7 days while traveling outside of his/her home country the Insurer will pay up to $1,000 for the cost of one economy round-trip air fare ticket to and hotel accommodations in, the place of the Hospital Confinement for one person designated by the Covered Person. Payment for meals, ground transportation and other incidentals are the responsibility of the family member or friend.

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

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

Loss	Benefit Amount	Participant	Partner	Child
Loss of life	100% of the Principal Sum	$10,000	$5,000	$5,000
Loss of one hand	50% of the Principal Sum	$ 5,000	$2,500	$2,500
Loss of one foot	50% of the Principal Sum	$ 5,000	$2,500	$2,500
Loss of sight in one eye	50% of the Principal Sum	$ 5,000	$2,500	$2,500

Loss of one hand or loss of one foot means the actual severance through or above the wrist or ankle joints. Loss of the sight of one eye means the entire and irrecoverable loss of sight in that eye.
If more than one of the losses stated above is due to the same Accident, the Insurer will pay 100% of the Principal Sum. In no event will the Insurer pay more than the Principal Sum for loss to the Covered Person due to any one Accident.
The Principal Sum is stated in the Schedule of Benefits.
There is no coverage for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.

HOW TO USE THE FIREBIRD WEBSITE

&

FIND A DOCTOR /HOSPITAL

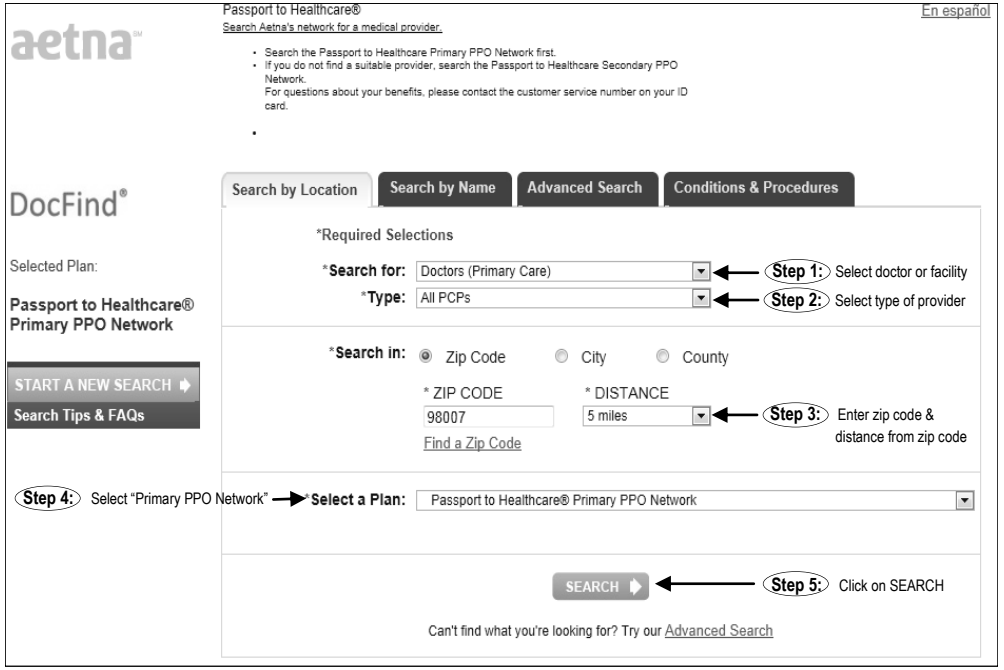
Please log on to: www.fiig-insurance.com and follow the steps below:

To get started, take the cursor to the left-hand side menu.

1. Take cursor to Student, but DO NOT click on it. Simply follow it the next window.
2. Take cursor to select the home state of your school.
3. Take cursor to the name of your school and you will have 5 different actions to choose from:
    - If you lose your booklet and need to print another one, click on Print Brochure. *You can also send the link to this website to your family in your home country if they wish to know what your coverage is under this policy.
    - If you lose your insurance ID card, please click on Request ID Card and this will allow you to email us requesting a new ID card.
    - Please see Page 14 for steps on finding a doctor or hospital.
    - Please see Page 15 on instructions on how to file a prescription claim.

TO SEARCH FOR A DOCTOR OR HOSPITAL

Select Find a Doctor or Hospital from the menu and this will open up to the Aetna DocFind search site.



***PLEASE NOTE:** We only use the Aetna PPO network of doctors on the list. We **do not** subscribe to any of Aetna's other services.

For questions regarding claims, coverage or enrollment, please contact Firebird directly at 206-909-8550.

TO FILE A PRESCRIPTION CLAIM:

Covered outpatient prescription drugs including oral contraceptives are reimbursed at 50% of the actual charge. *Please see below for steps on filing a prescription claim.

1. Take the prescription to any pharmacy. *You do not need to present your insurance id card. Inform the pharmacy that you will be filing a prescription claim with your insurance company.
2. Pay for the medication at full price. Make sure to keep all receipts and medication labels with information.
3. Visit www.fiig-insurance.com and select Print Prescription Form from the options.
4. Make a copy of the completed claim form with receipts and labels for your records.
5. Mail original form with attached receipts and labels to HTH Worldwide (address on top right hand corner of form).

* See sample of prescription claim form below:

Prescription Reimbursement Form **HTH Worldwide**

Please use a separate claim form for more than two prescriptions. Your cooperation in completing all items on the claim form, signing the back of the form and attaching all required documentation will help us to process your claim quickly and accurately.

PATIENT INFORMATION				INSURED INFORMATION (on ID Card)	
NAME: Family Name Given Name				Certificate Number:	Group Name:
Birth Date MM DD YY	Gender	Relationship to insured member		NAME: Family Name Given Name	
	☐ M ☐ F	☐ Self ☐ Son ☐ Spouse ☐ Daughter		Reimbursement Mailing Address:	
Does The Patient Have Other Health Insurance Coverage? ☐ Yes ☐ No					
Name of Other Health Insurance Company:					
Policy Number				Contact Phone Number:	Email Address:

Your Information in this section

PRESCRIPTION (Rx) INFORMATION

Each prescription submitted for reimbursement MUST include the drug quantity, drug name and strength. Be sure to **tape** the original paid pharmacy receipt(s) to the form and enter the total of both drug receipts in the space marked "TOTAL COST".

Tape original pharmacy receipt with prescription detail HERE	Tape original pharmacy receipt with prescription detail HERE
Original pharmacy receipt taped or stapled here.	Original medication label (extra loose label) taped or stapled here.

Total cost of prescriptions claimed: $ _____

HTH RX 04/13

TO FILE A PRESCRIPTION CLAIM (continued):

Page 2 of Prescription Claim Form

AUTHORIZATION

Certification and Release of Information: I certify that the information on this Claim Form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. If I checked the Pay the Provider box above, I authorize payment directly to those Health Care Providers described below, and/or indicated on the enclosed bills, of medical benefits otherwise payable to me, for services rendered by them. This claim will be returned if this claim form is not signed.

Except as otherwise indicated below, any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

For your protection, **California** requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

In **Florida**, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In **New Jersey**, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

Applicants applying for accident and health insurance in New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In **Oklahoma**, **WARNING**: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

In **Kentucky and Pennsylvania**, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In **Washington**, it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

X _____ _____
Signature of Insured Member Date

INSTRUCTIONS FOR THE USE OF YOUR CLAIM FORM

INSTRUCTIONS:

1. Provide the PATIENT/INSURED and PRESCRIPTION Information requested below. (PLEASE PRINT).
2. Complete a separate claim form for **each patient.**
3. The **original paid pharmacy receipts** showing prescription detail **must be taped to the form.** A cash register receipt is **not** satisfactory evidence of purchase. If you have more than two receipts for the same patient, use another form.
4. Remember to sign the form and enter the total amount of your receipts in the space provided.
5. Mail your prescription drug claims to the address above and keep a copy for your records.

SEND COMPLETED CLAIM FORM AND SUPPORTING DOCUMENTATION TO:

HTH Worldwide Insurance Services
P.O. Box 21545
Eagan, MN 55121

For Questions, please contact Firebird International Insurance Group, LLC
WA: 206.909.8550 OR: 503.729.7447
E-mail: admin@fiig-insurance.com

***DON'T FORGET TO MAKE A COPY BEFORE MAILING & KEEP COPY FOR YOUR RECORDS!!!**

COMPLAINTS AND APPEALS

As an Insured Participant, you have the right to ask questions, voice complaints and request a formal appeal to reconsider decisions we have made. Our goal is to listen to your concerns and improve our service to you.

When You Have Questions
Please call Customer Service with any questions you may have regarding your health plan. We suggest that you call your provider of care when you have questions about the health care services they provide.

When You Disagree With a Benefit Decision
If we declined to provide benefits in whole or in part, and you disagree with that decision, you have the right to request that we review that adverse benefit determination through a formal, internal appeals process.
This plan's appeals process will comply with any requirements as necessary under state and federal laws and regulations.

What is an adverse benefit determination?
Adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make payment for a benefit, in whole or in part for services based on:

- An individual's eligibility to participate in a plan or health insurance coverage, or rescission of coverage;
- A determination that a benefit is not a covered benefit;
- A preexisting condition exclusion, or other limitation on otherwise covered benefits;
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

When You Have an Appeal
After you are notified of an adverse benefit determination, you can request an internal appeal. Your internal appeal will be reviewed by individuals who were not involved in the initial adverse benefit determination. If the adverse benefit determination involved medical judgment, the review will be provided by a health care provider. They will review all of the information relevant to your appeal and will provide a written determination.

Who may file an internal appeal?
You or your authorized representative, someone you have named to act on your behalf, may file an appeal. To appoint an authorized representative, you must sign an authorization form and mail or fax the signed form to the address or phone number listed below. This release provides us with the authorization for this person to appeal on your behalf and allows our release of information, if any, to them.
Please call out Customer Service department for an authorization form.

How do I file an internal appeal?
You or your authorized representative may file an appeal by calling Customer Service or by writing to us at the address listed below. We must receive your appeal request within 180 calendar days of the date you were notified of the adverse benefit determination.

You can mail your written appeal request to:

BCS Insurance Company
c/o Worldwide Insurance Services, LLC
Attn: Appeals Department
One Radnor Corporate Center, Suite 100
Radnor, PA 19087

If you need help with filing an appeal, or would like a copy of the appeals process, please call Customer Service at the number listed on your insurance ID card. We will acknowledge our receipt of your request in writing.

CLAIMS ADMINISTERED BY:

HTH Worldwide

HTH Worldwide Insurance Services, Inc.
P.O. Box 30259
Tampa, FL 33630

UNDERWRITTEN BY:

BCS

BCS Insurance Company
Oakbrook Terrace, Illinois
NAIC #38245

To Find an In-Network Doctor or Hospital in your area, please visit:
www.fiig-insurance.com

PLAN SERVICED BY:

Firebird International Insurance Group, LLC
An Arizona Company
Mailing Address: P.O. Box 58563 ● Tukwila, WA 98138-1563
www.fiig-insurance.com ● email: admin@fiig-insurance.com
WA: 206.909.8550 All Other Areas: 1.800.899.4233
Fax: 1.800.346.9169

Rising Above and Beyond the Ordinary

This pamphlet contains a brief summary of the features and benefits for insured participants covered under Policy No. BCS-3457-13. It is not a contract of insurance. This policy complies with state mandated benefits for Oregon and therefore, Participants may be entitled to additional benefits and/or conditions. Please see the certificate of insurance by going online to www.fiig-insurance.com and begin by highlighting STUDENT, STATE, SCHOOL. If there is a difference between this program description and the certificate wording, the certificate controls.