

Insurance Guide

If you need to see a doctor, **please always call the toll-free 24/7 Customer Service Hotline before proceeding with any treatment:**

1 800 314 3938 (inside USA)
+1 818 735 3560 (outside USA)

Select the telephone prompts available for after-hours emergency assistance.



Carry your insurance ID card with you at all times.

When you go to a Doctor's office or to the Hospital, be sure to bring your insurance identification card. If the Doctor or Hospital needs to verify your coverage, they may call the Customer Service Hotline at **1 800 314 3938** in the USA or **+1 818 735 3560** outside the USA.

Don't use an Emergency Room in the USA unless your illness or injury is serious or life threatening, for example: Head injuries, Chest pain, Loss of consciousness, Life-threatening situations, Difficulty breathing, Seizures.

You will be charged up to \$350 (in addition to any other co-payments or deductibles required by your plan) if you use an Emergency Room (ER) for a condition that is not considered serious or life threatening.

Please read your Insurance Policy before starting your travel to review your Emergency Room (ER) co-payment.



Use an Urgent Care or Walk-in Clinic in the USA for Sports Injuries, Sore throats, Minor cuts, Cold/flu, Sprains and strains, Urinary tract infections, Earaches, Simple fractures or Minor burns.

Search for an Urgent Care or Walk-in Clinic at:

www.firsthealthbp.com

(Click on the 'Urgent Care Centers' link under the 'Providers' section)

or call Customer Service at: **1 800 314 3938**



In the event of hospitalization please call the 24/7 Emergency Service within 24 hours:

1 800 314 3938 (inside USA)

+1 818 735 3560 (outside USA)

Select the telephone prompts available for after-hours emergency assistance.

All pre-existing medical conditions are excluded from cover under this policy.

Pre-Existing condition means an injury, sickness, disease, or other condition that you had symptoms of or were diagnosed with during the 6 month period before your travel start date. Your condition may also be considered pre-existing if you take medication for the condition during the 6 month period before your travel start date, other than conditions that are stable and controlled entirely by medication. Please read the policy conditions document for more details on pre-existing conditions.



To access your complete insurance information please login to your personal MyInsurance area at: www.esecutive.com/MyInsurance.

To create your account, you will need:

- Your Last Name
- Your First Name
- Certificate / Policy Number
- Your Date of Birth



You can also use Facebook connect and log-in to MyInsurance with your Facebook account!

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SCHEDULE OF BENEFITS

POLICYHOLDER: FAIRMONT SPECIALTY TRUST

PARTICIPATING ORGANIZATION Cultural Homestay International

EFFECTIVE DATE: February 1, 2017

PLAN DOCUMENT NUMBER: LF005518

PREMIUM DUE DATE: Monthly in advance on the 1st of each month

PLAN DOCUMENT PERIOD: February 1, 2017 through January 31, 2018

CLASSES OF ELIGIBLE PERSONS:

A person may be covered only under one Class of Eligible Persons even though He or She may be eligible under more than one class. Also, a person may not be covered as a Dependent and a Plan Participant at the same time.

Class 1: Non-United States Citizen traveling outside their Home Country and has his or her true, fixed and permanent home and principal establishment outside of the United States States.

PART A: ACCIDENT AND SICKNESS BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Principal Sum: \$15,000.00

(Maximum Death benefit payable shall not exceed \$5,000 for an Insured Person aged 17 years or younger)

Aggregate Limit: \$500,000

<u>Loss of:</u>	<u>Benefit:</u> <u>(Percentage of Principal</u> <u>Sum)</u>
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Thumb and Index Finger of the Same Hand	25%

ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS

Benefits will be provided only for the Coverages listed below and will be paid only up to the amounts shown. Benefits are not provided for Coverages marked "NIL".

**Per Injury or Sickness Maximum for all
Injury and Sickness Medical** **\$250,000**

Deductible (Outpatient Services Only) **\$100**

Per Plan Participant Per Injury or Sickness:

Initial Treatment Period: 30 Days from the date of Injury or Sickness

Coinsurance: 100% of Usual, Reasonable & Customary (URC) Charges

Terms of Payment Full Excess

BENEFIT COVERAGE	Covered Benefit
Hospital Room & Board Benefit:	Semi-private room rate
Intensive Care/Cardiac Care Unit Benefit	URC
Hospital Miscellaneous Expense Benefit	URC
Surgeon (In or Outpatient) Benefits	URC
Assistant Surgeon Benefit	URC
Pre-Admission Testing Benefit	URC
Anesthesia Benefit	URC
Day Surgery Miscellaneous Benefit	URC
Diagnostic X-Ray and Lab Benefit	URC
Ambulance Benefit	URC
Physician Visit Benefit (Inpatient)	URC
Physician Visit Benefit (Outpatient)	URC
Consultant Physician Benefit	URC
Radiation/Chemotherapy Benefit	URC
Emergency Room Benefit	URC, subject to a \$350 copay, waived if admitted
Maternity and Pre-Natal Care Expense Benefit	URC
Emergency Dental Expense Benefit	URC
Palliative Dental	URC, up to \$200 maximum benefit per tooth
Physiotherapy Expense Benefit - Inpatient	URC
Physiotherapy Expense Benefit - Outpatient	URC, up to a \$2,500 maximum

Durable Medical Equipment Expense Benefit	URC
Emergency Medical Evacuation Expense Benefit	100% of actual expense
Emergency Medical Repatriation Expense Benefit	100% of actual expense
Emergency Reunion	100% of actual expense
Prescription Drug Benefit Covered Percentage:	URC

NOTES:

- We do not pay benefits for the amount of Eligible Expenses paid by You as Your Coinsurance or Co-pay amount.
- **Eligible Expenses** will be paid under the Inpatient benefits for Surgery and under the Outpatient benefits for Surgery, but not both for the same or related procedure.

PART B: TRAVEL ARRANGEMENT BENEFITS

Trip Interruption Benefit 100% of actual expense

DEFINITIONS

The male pronoun includes the female whenever used.

For the purposes of the Plan Document the capitalized terms used herein are defined as follows:

Additional terms may be defined within the provision to which they apply.

Accident means an unforeseeable event which:

- 1) Causes Injury to one or more Plan Participants; and
- 2) Occurs while coverage is in effect for the Plan Participant.

AIDS means Acquired Immune Deficiency Syndrome, as that term is defined by the United States Centers for Disease Control.

Benefit Period means the period of time from the date of the Accident causing the Injury for which benefits are payable, as shown in the Schedule of Benefits, and the date after which no further benefits will be paid.

Caregiver means an individual employed for the purpose of providing assistance with activities of daily living to the Plan Participant or to the Plan Participant's Immediate Family Member who has a physical or mental impairment. The Caregiver must be employed by the Plan Participant or the Plan Participant's Immediate Family Member. A Caregiver is not a babysitter; childcare service, facility or provider; or persons employed by any service, provider or facility to supply assisted living or skilled nursing personnel.

Child means the Plan Participant's natural Child, adopted Child (or Child placed in the Plan Participant's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Plan Participant has legal guardianship (proof will be required). A Child must reside with the Plan Participant in a parent-Child relationship. NOTE: In the event the Plan Participant shares physical custody of the Child with another parent, the requirement that the Child reside with the Plan Participant will be waived.

Child Caregiver means an individual providing basic childcare service needs for the Plan Participant's minor children under the age of 18 while the Plan Participant is on the Trip without the minor children. The arrangement of being the Child Caregiver while the Plan Participant is on the Trip must be made 30 or more days prior to the Scheduled Departure Date.

Civil Union Partner means a party to a civil union who is entitled to the same legal obligations, responsibilities, protections and benefits that are afforded a spouse. Throughout the Plan Document, a party to a civil union shall be included in any definition or use of the terms such as spouse, Immediate Family, dependent, next of kin, and other terms descriptive of spousal relationships. This includes the terms 'marriage' or 'married' or variations thereon. The term spouse or dependent includes civil union couples whenever used.

Class means a group of people defined by a common characteristic, including but not limited to demographic group and geographic region.

Coinsurance means the percentage of Eligible Expenses for which the Company is responsible for a specified covered service after the Deductible, if any, has been met.

Company means 100% by Advent Underwriting Limited on behalf of Advent Syndicate 780 at Lloyd's. Also hereinafter referred to as We, Us and Our.

Complications of Pregnancy means a condition which:

- When pregnancy is not terminated, requires medical treatment and whose diagnosis is distinct from pregnancy but is adversely affected by or are caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; and (i) other similar medical and surgical conditions of comparable severity related to pregnancy.
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is

terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible;

Complications of Pregnancy will not include:

- False Labor;
- Occasional spotting;
- Physician prescribed rest during the period of pregnancy;
- Morning Sickness; and
- Similar conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a complication of pregnancy if the cesarean section is *non-elective*. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the Child or mother.

Co-Payment means a specified charge that the Plan Participant is required to pay when a medical service is rendered.

Cosmetic Surgery means the surgical alteration of tissue primarily for the improvement of appearance rather than to improve or restore bodily functions.

Covered Accident means an Accident that occurs while coverage is in force for a Plan Participant and results in a Covered Loss for which benefits are payable.

Covered Loss or Covered Losses means an accidental death, dismemberment, Sickness or other Injury covered under the Plan Document and indicated on the Schedule of Benefits.

Custodial Care means that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Plan Participant, whether or not totally disabled, in the activities of daily living.

Deductible means the dollar amount of Eligible Expenses which must be incurred and paid by the Plan Participant before benefits are payable under the Plan Document. It applies separately to each Plan Participant.

Dentist means a legally licensed doctor of dental surgery; dental medicine or dental science. A dental hygienist who works within the scope of his/her license, under the supervision of a Dentist, is a covered practitioner.

Dependent means a Plan Participant's:

- 1) lawful spouse, if not legally separated or divorced, or Domestic Partner]or Civil Union Partner.
- 2) unmarried Children under age 26.

The age limitations will not apply to a Plan Participant's unmarried Child who is dependent on the Plan Participant or other care providers for lifetime care and supervision, and incapable of self-sustaining employment by reason of mental or physical handicap that occurred before age 26. Proof of such dependence and incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.

Domestic Partner means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Plan Participant and shared financial assets/obligations with the Plan Participant. Both the Plan Participant and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract.

Neither the Plan Participant nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

Economy Transportation means the lowest published available transportation rate for a ticket on a Common Carrier matching the original class of transportation that the Plan Participant purchased for the Plan Participant's Trip.

Eligible Expenses means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Plan Participant for the Medically Necessary treatment of an Injury. Eligible Expenses must be incurred while the Plan Document is in force.

Emergency means a Sickness or Injury for which the Plan Participant seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause:

- His life or health would be in serious jeopardy, or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn Child;
- His bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

Experimental/Investigational means that a drug, device or medical care or treatment will be considered experimental/investigational if:

- The drug or device cannot be lawfully marketed without approval of the Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
- Reliable Evidence show that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or
- Reliable Evidence show that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device or medical care at the time the expense is incurred.

Management staff in Our Claims Department or a Claims Payor acting on Our behalf will make the determination if the drug, device or medical care is Experimental/Investigational based on the above criteria.

Extended Care Facility means an institution operating pursuant to applicable laws that is engaged in providing, for a fee, inpatient skilled nursing care and related services under the supervision of a Physician and Registered Nurses. It must have facilities for 10 or more inpatients and maintain medical records of all its patients.

He, His and Him includes "she", "her" and "hers."

Health Care Plan means any contract, Plan Document or other arrangement for benefits or services for medical or dental care or treatment under:

- 1) Group or blanket insurance, whether on an insured or self-funded basis;
- 2) Hospital or medical service organizations on a group basis;
- 3) Health Maintenance Organizations on a group basis.
- 4) Group labor management plans;
- 5) Employee benefit organization plan;
- 6) Professional association plans on a group basis; or
- 7) Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended; or
- 8) Automobile no-fault coverage (unless prohibited by law).

Home Country means the country where a Plan Participant has his or her true, fixed and permanent home and principal establishment.

Home Health Care means nursing care, treatment and Daily Living Services provided in the Plan Participant's home as part of an overall extended treatment plan. To qualify for Home Health Care Benefits:

- 1) the Home Health Care plan must be established and approved by the attending Physician, including certification that confinement in a Hospital or Extended Care Facility would be required if it were not for Home Health Care; and Necessary care and treatment are not available from a Plan Participant's Immediate Family Member or other persons residing with the Plan Participant without causing undue hardship;
- 2) nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified Home Health Care agency and nursing service; and
- 3) Daily Living Services must be provided by the attending Physician or by the provider of the nursing care service.

"Daily Living Services" are cooking, feeding, bathing, dressing and personal hygiene services that are necessary to a person's care and health.

Home Health Care consists of, but shall not be limited to, the following:

- Part time and intermittent skilled nursing services: services given to the Plan Participant at least once every 60 days or as frequently as a few hours per day, several days per week.
- Therapeutic services: physical therapy occupational therapy; speech and hearing therapy; and
- Medical social services, medical supplies, drugs and medicines, related pharmaceutical services and laboratory services to the extent such charges or costs would have been covered under the Evidence of Coverage if the Plan Participant had remained in the Hospital.

Host Country means any country other than the country where a Plan Participant has his or her true, fixed and permanent home and principal establishment.

Hospital means an institution licensed, accredited or certified by the State that:

- 1) Operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons;

- 2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
- 3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call;
- 4) Has a staff of one or more licensed Physicians available at all times;
- 5) Provides organized facilities for diagnosis, treatment and surgery, either
 - a) on its premises; or
 - b) in facilities available to it, on a pre-arranged basis;
- 6) Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
- 7) Is not a place for drug addicts, alcoholics or the aged.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

- 1) the Joint Commission of Accreditation of Hospitals; or
- 2) the American Osteopathic Association; or
- 3) the Commission on the Accreditation of Rehabilitative Facilities.

In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Eligible Expense under the Plan Document.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

Immediate Family means a Plan Participant's spouse, domestic partner, civil union partner, parent (includes Step-parent), Child(ren) (includes legally adopted or step Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws). A Member of the Immediate Family includes an individual who normally lives in the Plan Participant's household.

Injury means bodily harm which results independently of disease or bodily infirmity, from an Accident after the effective date of a Plan Participant's coverage under the Plan Document, while the Plan Document is in force as to the person whose Injury is the basis of the claim. All injuries to the same Plan Participant sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Inpatient means a Plan Participant who is confined in an institution and is charged for room and board.

Insurance means the coverage that is provided under the Plan Document.

Intensive Care Unit means a cardiac care unit or other unit or area of a Hospital which meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Intoxicated means a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Plan Participant is located at the time of an incident.

Master Application means the Application for the Master Plan Document.

Maximum Benefit means the largest total amount of Eligible Expenses that the Company will pay for the Plan Participant as shown in the Plan Participant's Schedule of Benefits.

Medically Necessary means a treatment, drug, device, service, procedure or supply that is:

- 1) Required, necessary and appropriate for the diagnosis or treatment of a Sickness or Injury;
- 2) Prescribed or ordered by a Physician or furnished by a Hospital;
- 3) Performed in the least costly setting required by the condition;
- 4) Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

The purchasing or renting air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them, and general exercise equipment are not considered Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may consider the cost of the alternative to be the Eligible Expense.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental/Investigational or for research purposes;
- Is provided for education purposes or the convenience of the Plan Participant, the Plan Participant's family, Physician, Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the person's condition or the quality of medical care;
- Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
- Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- It can be safely provided to the patient on a less cost effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.

Mental or Nervous Disorder means any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the medical care or treatment is rendered to a Plan Participant.

Mountaineering means the sport, hobby, or profession of walking, hiking, and climbing up mountains either: 1) utilizing harnesses, ropes, crampons, or ice axes; or 2) ascending 4,500 meters or above.

Natural Disaster means a flood, hurricane, tornado, earthquake, mudslide, tsunami, avalanche, landslide, volcanic eruption, fire, wildfire or blizzard that is due to natural causes.

Natural Teeth means the major portion of the individual tooth which is present, regardless of fillings and caps; and is not carious, abscessed, or defective.

Occurrence means all losses or damages that are attributable directly or indirectly to one cause or one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one Occurrence without regard to the period of time or the area over which such losses occur.

Outpatient means a Plan Participant who receives care in a Hospital or another institution, including; ambulatory surgical center; convalescent/skilled nursing facility; or Physician's office, for a Sickness or Injury, but who is not confined and is not charged for room and board.

Outpatient Surgical Facility means a surgical or medical center which has (1) permanent facilities for surgery; (2) organized medical staff of Physicians and registered graduate Registered Nurses; (3) is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under law.

Out-of-Pocket Maximum means the maximum dollar amount the Plan Participant is responsible to pay during a Plan Document Term. After the Plan Participant has reached the Out-of-Pocket Maximum, the Plan Document pays 100% of Eligible Expenses for the remainder of the Plan Document Term. The Out-of-Pocket Maximum is met by accumulated Deductible, Coinsurance and Co-payments. Penalties and amounts above the Usual, Reasonable and Customary Expenses do not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is shown on the Schedule of Benefits.

Parachuting means an activity involving the breaking of a free fall from an airplane using a parachute.

Participating Organization means any organization which elects to offer coverage by completing a Participation Agreement and that has been approved by the Company to sponsor coverage under the Plan Document.

Participation Agreement means the agreement completed by a Participating Organization for insurance under the Master Plan Document.

Permanent Residence means the country where a Plan Participant has his or her true, fixed and permanent home and principal establishment, and to which he or she has the intention of returning.

Physician means a person who is a qualified practitioner of medicine. As such, He or She must be acting within the scope of his/her license under the laws in the state in which He or She practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Plan Participant, a Plan Participant's Spouse, son, daughter, father, mother, brother or sister or other relative.

Physical Therapy means any form of the following administered by a Physician: (1) physical or mechanical therapy; (2) diathermy, (3) ultra-sonic therapy; (4) heat treatment in any form; or (5) manipulation or massage.

Plan Participant means a Person and Dependent eligible for coverage as identified in the Enrollment/Application a Non-United States Citizen traveling outside their Home Country and has his or her true, fixed and permanent home and principal establishment outside of the United States for whom proper premium payment has been made when due, and who is therefore a Plan Participant under the Plan Document.

Plan Document means this document and any end endorsements, riders or amendments that will attach during the Period of Coverage.

Plan Period means the period of time following the Plan Document's Effective Date, as shown on the Schedule of Benefits.

Pre-Existing Condition means an Injury, Sickness, disease, or other condition during the 6-month period immediately 6 months prior to the date that the Plan Participant's coverage is effective for which the Plan Participant: 1) received or received a recommendation for a test, examination, or medical treatment for a condition which first manifested itself, worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment; or 2) took or received a prescription for drugs or medicine. Item (2) of this definition does not apply to a condition which is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the 6-month period before coverage is effective under the Plan Participant's Plan.

Pregnancy means the physical condition of being pregnant, including Complication of Pregnancy.

Prescription Drugs means drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the Food and Drug Administration.

Registered Nurse means a licensed registered professional Registered Nurse (R.N.).

Rehabilitation Facility means a non-residential facility that provides therapy and training rehabilitation services at a single location in a coordinated fashion, by or under the supervision of a physician pursuant to the law of the jurisdiction in which treatment is provided. The center may offer occupational therapy, physical therapy, vocational training, and special training such as speech therapy. The facility may be either of the following:

- 1) A Hospital or a special unit of a Hospital designated as a Rehabilitation Facility; or
- 2) A free standing facility.

Service Provider means a Hospital, convalescent/skilled nursing facility, ambulatory surgical center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, alcohol or drug dependency treatment center, birthing center, Physician, Dentist, chiropractor, licensed medical practitioner, Registered Nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility that the Company approves.

Sickness means illness or disease which requires treatment by a Physician while covered by this Plan Document. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

Skilled Nursing Facility means a facility that provides skilled nursing 24 hours a day, seven days a week, under the supervision of a Registered Nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A Skilled Nursing Facility provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge.

Spouse means lawful spouse, if not legally separated or divorced, [or Domestic Partner]or Civil Partner.

Substance Abuse means alcohol, drug or chemical abuse, overuse or dependency.

Surgery or Surgical Procedure means an invasive diagnostic procedure; or the treatment of Sickness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.

Third Party means a person or entity other than the Plan Participant, the Policyholder, the Participating Organization or the Company.

Transportation Expense means the cost of Medically Necessary conveyance, personnel, and services or supplies.

Traveling Companion means a person or persons whose names appear with the Plan Participant's on the same Travel Arrangements and who, during the Trip, will accompany the Plan Participant.

Trip means a scheduled trip for which coverage for Travel Arrangements is requested and the premium is paid prior to the Plan Participant's actual or Scheduled Departure Date of the Plan Participant's Trip from the Plan Participant's primary residence for which coverage is requested and the premium is paid.

Usual, Reasonable and Customary means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred. The most common charge means the lesser of:

- The actual amount charged by the provider;
- The negotiated rate; or

- The charge which would have been made by the provider (Physician, Hospital, etc.) for a comparable service or supply made by other providers in the same Geographic Area, as reasonable determined by Us for the same service or supply.

"Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Usual, Reasonable and Customary Charges, Fees or Expenses as used in the Plan Document to describe expense will be considered to mean the percentile of the payment system in effect at Plan Document issue as shown on the Schedule of Benefits.

We, Our, Us means 100% by Advent Underwriting Limited on behalf of Advent Syndicate 780 at Lloyd's underwriting this insurance.

You, Your, Yours, He or She means the Plan Participant who meets the eligibility requirements of the Plan Document and whose insurance under the Plan Document is in force.

ELIGIBILITY FOR INSURANCE

Persons eligible to be a Plan Participant under the Plan Document are those persons described as an ELIGIBLE CLASS on the Schedule of Benefits. This includes anyone who may become eligible while the Plan Document is in force.

We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

This insurance is not subject to, and will not be administered as a PPACA (Patient Protection and Affordable Care Act) insurance plan. PPACA requires certain U.S. residents and citizens obtain PPACA compliant insurance coverage. This plan is not designed to cover U.S. residents and citizens. This Plan Document is not subject to guaranteed issuance or renewal.

EFFECTIVE DATES OF INSURANCE:

Plan Document Effective Date. The Plan Document begins on the Plan Document Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Participating Organization and will continue in force until either a) the Plan Document Expiration Date stated in the Schedule; or b) the Plan Document is cancelled pursuant to the terms of the Plan Document.

Plan Participant's Effective Date for Trip Interruption Coverage:

Coverage begins when the Plan Participant departs on the first scheduled Travel Arrangement (or if they must use an alternate travel arrangement after the Scheduled Departure Date to reach the Trip destination, on the Scheduled Departure Date) for the Plan Participant's Trip. This is the Plan Participant's "Effective Date" and time for Trip Interruption.

Plan Participant's Effective Date for all other Coverages:

A Person will become a Plan Participant under the Plan Document, provided proper premium payment is made, on the latest of:

- 1) The Effective Date of the Plan Document; or
- 2) The date the Company receives a completed application or enrollment form; or
- 3) The day He becomes eligible, subject to any required waiting period, according to the referenced date requested and shown in the Schedule of Benefits; or
- 4) The moment He departs their Home Country airspace; or

5) The Date requested by the Participating Organization.

TERMINATION DATE OF INSURANCE:

Plan Document Termination Date

Termination takes effect at 11:59 P.M. time at the address of the Participating Organization on the date of termination. Termination by the Participating Organization or by the Company will be without prejudice to any claims originating prior to the date of termination.

The Plan Document terminates automatically on the earlier of:

- 1) The Plan Document Expiration Date shown in the Plan Document; or
- 2) The premium due date if premiums are not paid when due, subject to any grace period.

Failure by the Participating Organization to pay all required premiums due by the last day of the grace period shall be deemed notice by the Participating Organization to the Company to terminate the Plan Document on the last day of the period for which premiums have been paid.

The Plan Document may be terminated by the Participating Organization or the Company as of any premium due date by giving written notice to the other and the Participating Organization at least 31 days prior to such date.

The Participating Organization and the Company may terminate the Plan Document at any time by written mutual consent.

If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Participating Organization will owe the Company the difference.

Termination Date of the Participating Organization. Coverage for a Participating Organization will terminate on the earliest of the following dates:

- 1) The date the Participating Organization no longer meets the definition of a Participating Organization; or
- 2) The date ending the Coverage Month for which the last premium payment is made for the Participating Organization's insurance.

Termination of the Plan Document, or termination of coverage for a Participating Organization, under any conditions will be without prejudice to any claim incurred prior to termination.

Plan Participant's Termination Date for all other Coverages:

Insurance for a Plan Participant will end on the earliest of:

- 1) The date He is no longer in an Eligible Class; or
- 2) The date the Plan Participant returns to his or her Home Country; or
- 3) The date shown on the Evidence of Coverage issued by the Company; or
- 4) The date the Plan Participant becomes a permanent resident of the United States or;
- 5) The date He reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
 - a) The date the premium is fully earned; or
 - b) The Expiration Date of the Plan Document.

This does not include Reserve or National Guard duty for training;

- 6) The end of the period for which the last premium contribution is made; or
- 7) The date the Plan Document is terminated; or
- 8) The date the Plan Participant requests, in writing, that his/her coverage be terminated; or

- 9) The date the Plan Participant's participation in the Program terminates]; or
- 10) The date the Plan Participant's Trip is completed; or
- 11) The expiration date of the term of coverage, requested by the Participating Organization.

PREMIUM PROVISIONS

Premiums:

The Company provides insurance in return for premium payments. The premium shown in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium due dates are the first of every month unless otherwise stated in the Plan Document. Premium payment made in advance or for more than a one month period will not affect any provisions of the Plan Document with regard to change. Premiums due for the Plan Document will be remitted to Us by an officer of the Participating Organization or by any other person designated by the Participating Organization to remit such premiums.

Failure by the Participating Organization to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

Grace Period:

A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period provided the Participating Organization pays all the premiums due by the last day of the grace period, unless notice has been sent, in accordance with the TERMINATION provision, of the intent to terminate coverage under the Plan Document. Coverage will end if the premium is not paid by the end of the grace period.

Changes in Premium Rate

The Company may change the premium rates from time to time with at least 60 days advanced written or authorized electronic notice. Notice will be sent to the Participating Organization's most recent address in Our records.

No change in rates will be made until 12 months after the Plan Document Effective Date. However, the Company reserves the right to change rates at any time if any of the following events occur:

- 1) A change in the terms of the Plan Document.
- 2) A subsidiary, division, affiliated organization or eligible class is added or deleted to the Plan Document.
- 3) A change in the factors bearing on the risk assumed.
- 4) A misrepresentation in the information relied on in establishing the rate for the Plan Document
- 5) A change in the experience rating.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.

Reinstatement

The Plan Document may be reinstated within 31 days of lapse if it is lapsed for nonpayment of premium, if the Participating Organization submits written application to the Company, the Company accepts the application and the Participating Organization makes payment of all overdue premiums.

SCOPE OF COVERAGE

Benefits are payable under the Plan Document for Eligible Expenses incurred by a Plan Participant for the items stated in the, Schedule of Benefits. Benefits will be payable to either the Plan Participant or the Service Provider for Eligible Expenses incurred outside the Plan Participant's Home Country. Coverage is available 24 hours per day while traveling to, from and while at the Plan Participant's destination.

The charges enumerated herein will in no event include any amount of such charges which are in excess of Usual, Reasonable and Customary charges. If the charge incurred is in excess of such average charge such excess amount will not be recognized as an Eligible Expense. All charges will be deemed to be incurred on the date such services or supplies, which give rise to the expense or charge, are rendered or obtained.

We will provide the benefits described in the Plan Document to all Plan Participants who suffer a Covered Loss which:

- 1) Is within the scope of the **DESCRIPTION OF BENEFITS PROVISIONS**; and
- 2) Occurs while the person is a Plan Participant under the Plan Document.

Terms of Payment for Benefits:

Full Excess Medical Expense:

If an Injury or Sickness to the Plan Participant results in his incurring Eligible Expenses for any of the services in the SCHEDULE OF BENEFITS, We will pay the Eligible Expenses incurred, subject to any applicable Deductible Amount, Co-Payment and Coinsurance Percentage, that are in excess of Expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The Plan Participant must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for the treatment of a covered Injury or Sickness:

- 1) While the person is a Plan Participant under the Plan Document; or
- 2) During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Expense must be incurred within the time frame shown on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under the Plan Document is shown on the SCHEDULE OF BENEFITS and is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

DESCRIPTION OF BENEFITS

PART A: ACCIDENT AND SICKNESS BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT

If, within one year from the date of an Accident or Injury covered by the Plan Document that occurs during the Plan Participant's Trip, the Plan Participant suffers from a Covered Loss listed below, We will pay the percentage of the Principal Sum set opposite the loss in the table below. If the Plan Participant sustains more than one such Loss as the result of one Accident, We will pay only one amount, the largest to which he is entitled. This amount will not exceed the Principal Sum which applies for the Plan Participant. The Principal Sum is the Maximum Benefit Amount shown in Schedule of Benefit.

Benefits are payable if such Injury:

- 1) Occurs during the course of time the Plan Participant is covered under the Plan Document;
- 2) is sustained during such Trip while the Plan Participant is riding as a passenger (but not as a pilot, operator or member of the crew) in or on, boarding or alighting from:
 - a) any civilian aircraft having a current and valid Airworthiness Certificate, and piloted by a person who then holds a valid and current certificate of competency of a rating authorizing him to pilot such aircraft or
 - b) any transport type aircraft operated by the Military Airlift Command (MAC) of the United States, or by the similar air transport service of any duly constituted governmental authority of any other recognized country or
 - c) a Common Carrier

provided that this Insurance will not apply while such Plan Participant is riding in any civilian or military aircraft other than as expressly described above, unless previously consented to in writing by the Company.

<u>Loss of:</u>	<u>Benefit:</u> <u>(Percentage of Principal Sum)</u>
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Thumb and Index Finger of the Same Hand	25%

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint.

Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

Severance means the complete separation and dismemberment of the part from the body.

EXPOSURE TO THE ELEMENTS OR DISAPPEARANCE

Subject to all other terms and conditions of the Plan Document, We will:

- 1) Pay the applicable benefit under **BENEFITS FOR ACCIDENTAL DEATH AND DISMEMBERMENT** for a Plan Participant's loss specified therein, which results from unavoidable exposure to the elements or disappearance due to:
 - a) The forced landing; stranding; sinking; or wrecking of a vehicle in which a Plan Participant was traveling; and
 - b) Such Occurrence occurs from an Accident for which the Plan Document provides coverage; or
- 2) Presume that a Plan Participant has died if:
 - a) A vehicle in which he is traveling disappears; sinks; is stranded; or is wrecked; as a result of an Accident for which the Plan Document provides coverage; and
 - b) His body is not found within one year of the Occurrence of (2)(a) above.

These benefits will not duplicate any other benefits payable under the Plan Participant's Evidence of Coverage or any coverage(s) attached to the Plan Participant's Evidence of Coverage.

Covered Accident Medical Expenses incurred due to Injury only are paid up to the maximum Accident Medical Expense Benefit Limit, for the following eligible expenses: treatment by a Physician; care or service from a Hospital; services provided by an ambulatory medical-surgical facility; Home Health Care from a licensed home health agency, but only if continued Hospital care would have otherwise been required; attendance of a graduate Registered Nurse; X-ray examination; or, use of an ambulance.

AGGREGATE LIMIT - Accidental Death & Dismemberment Only

The Aggregate Limit of liability is shown in the Schedule of Benefits. We will NOT be liable for any amount over such limit for any one Accident.

If the total amount of benefits to be paid for Accidental Death & Dismemberment under this Plan Document is more than the Aggregate Limit shown in the Schedule of Benefits, the benefit amount payable for a Plan Participant's loss will be determined as a proportionate share of the Aggregate Limit for all Plan Participants.

ACCIDENT and SICKNESS MEDICAL EXPENSE BENEFITS

We will pay Accident and Sickness Medical Expense Benefits for Eligible Expenses. These benefits are subject to the Deductibles, Co-Payment, Coinsurance Factors, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident and Sickness Medical Expense Benefits are only payable:

- 1) for Usual, Reasonable and Customary Charges incurred after the Deductible has been met;
- 2) for those Medically Necessary Eligible Expenses incurred by or on behalf of the Plan Participant;
- 3) for Eligible Expenses incurred while the coverage is in force.

No benefits will be paid for any expenses incurred that are in excess of Usual, Reasonable and Customary Charges.

Eligible Medical Expenses include:

- 1) **Hospital Admission Expenses:** Charges for each hospital admission.
- 2) **Outpatient Pre-Surgical Testing benefit** – charges for Pre-surgical testing. A scheduled surgical procedure must occur within 3 days of the testing.
- 3) **Nursing Services** – Outpatient Charges for nursing services by a Registered Nurse or Licensed Professional.
- 4) **Skilled Nursing Facility** - charges for services as described in the schedule of benefits. The benefit provides skilled nursing 24 hours a day, seven days a week, under the supervision of a registered nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A SNF provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence.

A SNF confinement must take place within 14 days from a hospital discharge and must represent care for the same condition which required hospitalization that lasted a minimum of three days. Care may not be custodial in nature (e.g., care which could be performed at home). The facility may not be primarily a place which provides general care for the aged.]
- 5) Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.
- 6) Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items.

ADDITIONAL BENEFITS

HOSPITAL ROOM & BOARD BENEFIT

We will pay charges for the most common [semi-private] daily room rate for each day of the Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule]. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge. Hospital Room and Board expenses will include floor nursing while confined in a ward or semi-private room of a Hospital and other Hospital services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's average charge for semiprivate room and board accommodation.

INTENSIVE CARE/CARDIAC CARE UNIT BENEFIT

We will pay charges for each day of Intensive Care/Cardiac Care Unit confinement, up to the Daily Maximum Benefit shown in the schedule] per day. This payment is in lieu of payment for the Hospital Room and Board charges for those days and includes nursing services.

HOSPITAL MISCELLANEOUS EXPENSE BENEFIT

We will pay for services, supplies and charges during a Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule per day. Miscellaneous services include 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; and blood and blood transfusions. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

DAY SURGERY MISCELLANEOUS BENEFIT

We will pay Day Surgery Miscellaneous benefits for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs or medicine; therapeutic services; and supplies, on an outpatient basis.

SURGEON (IN OR OUTPATIENT) BENEFITS

We will pay charges for:

- 1) A Physician, for primary performance of a surgical procedure, up to the Maximum Benefit Amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Eligible Expenses for the additional surgeries.

ASSISTANT SURGEON BENEFIT

If, in connection with such operation, a Plan Participant requires the services of an Assistant Surgeon, We will pay the Covered Percentage of the Covered Expense incurred.

PRE-ADMISSION TESTING BENEFIT

We will pay benefits for charges for Pre-admission testing (inpatient confinement must occur within 3 days of the testing).

ANESTHESIA BENEFIT

We will pay benefits for Anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.

DIAGNOSTIC X-RAY AND LABORATORY BENEFIT

We will pay the benefit if the Plan Participant requires diagnostic x-ray and/or laboratory examinations and services due to a Covered Loss, up to the Maximum Benefit per Covered Accident or Sickness indicated in the Schedule of Benefits. Outpatient x-ray and laboratory tests are limited to the amount shown in the Schedule of Benefits.

AMBULANCE BENEFIT

When, by reason of Injury or Sickness, a Plan Participant requires the use of a community or Hospital Ambulance in a Medical Emergency, We will pay a Benefit Amount up to a Maximum shown in the schedule], within the metropolitan area in which the Plan Participant is located at that time the service is used. Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, the scene of the Accident or Medical Emergency to a

Hospital or between Hospitals. Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area

Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness or if the Plan Participant is in a rural area, then air ambulance transportation to the nearest metropolitan area will be considered a Eligible Expense. Air Ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

PHYSICIAN VISIT BENEFIT (INPATIENT)

We will pay charges by a Physician for other than pre- or post-operative care for in-Hospital visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.

PHYSICIAN VISIT BENEFIT (OUTPATIENT)

We will pay charges by a Physician for office visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Office Visits.

Total visits per Injury will not exceed the combined Maximum shown in the Schedule of Benefits for All In-Hospital and Office Physician's Visits.

CONSULTANT PHYSICIAN BENEFIT

If, by reason of Injury or Sickness, a Plan Participant requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending Physician for the purpose of confirming or determining a diagnosis, We will pay the Covered Percentage of the Covered Expenses incurred.

RADIATION/ CHEMOTHERAPY THERAPY EXPENSE BENEFIT

We will pay the Covered Percentage for the Covered Expenses incurred by a Plan Participant for drugs used in antineoplastic therapy and the cost of its administration. Coverage is provided for any drug approved by the Federal Food and Drug Administration (FDA), regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug was approved by the FDA, so long as:

- 1) the drug is ordered by a Physician for the treatment of a specific type of neoplasm;
- 2) the drug is approved by the FDA for use in antineoplastic therapy;
- 3) the drug is used as part of an antineoplastic drug regimen;
- 4) current medical literature substantiates its efficacy, and recognized oncology organizations generally accept the treatment; and
- 5) the Physician has obtained informed consent from the patient for the treatment regimen that includes FDA approved drugs for off-label indications.

EMERGENCY ROOM BENEFIT

We will pay this benefit if the Plan Participant requires Emergency Room treatment due to a Covered Loss resulting directly and independently of all other causes from a Covered Accident or Sickness.

Emergency Room means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.

Services including physician charges and related x-ray/laboratory interpretations will be paid under this benefit.

MATERNITY AND PRE-NATAL CARE BENEFIT

When a covered Maternity is incurred by a Plan Participant the Company will pay the Usual, Reasonable and Customary medical expenses in excess of the Deductible and Coinsurance as stated in the Schedule of Benefits, Maternity. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits Maternity, as to Eligible Expenses during any one period of individual coverage.

Benefits will be payable for Eligible Expenses an Plan Participant incurs before, during, and after delivery of a Child, including Physician, Hospital, laboratory, and ultrasound services. Coverage for the Inpatient postpartum stay for the Plan Participant and her newborn Child in a Hospital, will, at a minimum, be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their guidelines for Perinatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the Plan Participant Person's attending Physician determines further Inpatient postpartum care is not necessary for the Plan Participant or her newborn Child provided the following are met:

- 1) In the opinion of the Plan Participant Person's attending Physician, the newborn Child meets the criteria for medical stability in the guidelines for Perinatal Care prepared by the Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of:
 - a) The antepartum, intrapartum, postpartum course of the mother and infant;
 - b) The gestational stage, birth weight, and clinical condition of the infant;
 - c) The demonstrated ability of the mother to care for the infant after discharge; and
 - d) The availability of post discharge follow up to verify the condition of the infant after discharge; and
2. One (1) at-home post delivery care visit is provided to the Plan Participant at her residence by a Physician or Registered Nurse performed no later than forty-eight (48) hours following discharge of the Plan Participant and her newborn Child from the Hospital. Coverage for this visit includes, but is not limited to:
 - a) Parent education;
 - b) Assistance in training in breast or bottle feeding; and
 - c) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the Plan Participant or newborn Child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. (At the Plan Participant Person's discretion, this visit may occur at the Physician's office.)

EMERGENCY DENTAL EXPENSE BENEFIT

We will pay benefits as described in the Schedule of Benefits for expenses for emergency dental treatment due to Injury to natural teeth. We will pay benefits as described in the Schedule of Benefits for expenses incurred during the Plan Participant's Trip for emergency dental treatment. Only expenses for emergency dental treatment to natural teeth incurred during the Trip will be reimbursed. Expenses incurred after the Trip are not covered.

PALLIATIVE DENTAL

We will pay benefits as described in the Schedule of Benefits for eligible expenses for Palliative Dental. An eligible Palliative Dental condition will mean emergency pain relief treatment to natural teeth.

PHYSIOTHERAPY EXPENSE BENEFIT

We will pay benefits as described in the Schedule of Benefits for eligible Physiotherapy expenses incurred by the Plan Participant. We will pay Usual, Reasonable and Customary expenses in excess of the Deductible as stated in the Schedule of Benefits. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Expenses during any one period of individual coverage.

For the purpose of this section, **Physiotherapy means** charges for physiotherapy if recommended by a Physician for the treatment of a specific Disablement and administered by a licensed physiotherapist as an outpatient, up to up to the maximum amount shown in the Schedule of Benefits per day for the Outpatient Physiotherapy benefit.

Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic, adjustments, manipulation, acupuncture, massage or any form of physical therapy.

DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, a Plan Participant requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Eligible Expenses incurred by a Plan Participant for such Durable Medical Equipment. We pay the Covered Percentage of the Eligible Expenses incurred by a Plan Participant for the purchase or rental of such item. In no event shall we pay rental charges in excess of the purchase price. Any rental charges paid will be applied toward the cost of the purchase price if the equipment is purchased at a later date. If Durable Medical Equipment is purchased, it is Our property and is to be returned to Us, at Our expense, upon completion of a Plan Participant's need, if so requested by Us.

We do not pay for the replacement of Durable Medical Equipment.

Durable Medical Equipment which includes braces and appliances means medical equipment that:

- 1) is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
- 2) can withstand long-term repeated use without replacement;

- 3) is not useful in the absence of an Injury or Sickness; and
- 4) can be used in the home without medical supervision.

EMERGENCY MEDICAL EVACUATION, MEDICAL REPATRIATION AND RETURN OF REMAINS

When You suffer loss of life for any reason or incur a Sickness or Injury during the course of Your Trip, the following benefits are payable, up to the Maximum Benefit Amount shown in the Schedule of Benefits.

- 1) **Emergency Medical Evacuation:** If the local attending Legally Qualified Physician and the authorized travel assistance company determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment.
- 2) **Medical Repatriation:** If the local attending Legally Qualified Physician and the authorized travel assistance company determine that it is Medically Necessary for You to return to Your primary place of residence because of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred within 30 days from the date of the Covered Loss, will be paid for Your return to Your primary place of residence or to a Hospital or medical facility closest to Your primary place of place of residence capable of providing continued treatment via one of the following methods of transportation, as approved, in writing, by the authorized travel assistance company:
 - a) one-way Economy Transportation;
 - b) commercial air upgrade (to Business or First Class), based on Your condition as recommended by the local attending Legally Qualified Physician and verified in writing and considered necessary by the authorized travel assistance company; or
 - c) other covered land or air transportation including, but not limited to, commercial stretcher, medical escort, or the Usual and Customary Charges for air ambulance, provided such transportation has been pre-approved and arranged by the authorized travel assistance company. Transportation must be via the most direct and economical route.
- 3) **Return of Remains:** In the event of Your death during a Trip, the expense incurred within 30 days from the date of the Covered Loss will be paid for minimally necessary casket or air tray, preparation and transportation of Your remains to Your primary place of residence or to the place of burial.

EMERGENCY MEDICAL REUNION BENEFIT

When a Plan Participant is traveling alone and is hospitalized for more than 5 days, the Company will arrange and pay for round-trip economy-class transportation for one individual selected by the Plan Participant from the Plan Participant's Home Country to the location where the Plan Participant is hospitalized and return to the current Home Country. The benefits payable will include:

1. The cost of a round trip economy air fare up to the maximum stated in the Schedule of Benefits;
2. Reasonable travel and accommodation expenses incurred in relation to the Emergency Medical Reunion up to the maximum stated in the Schedule of Benefits;

3. Hotel and meals to a maximum of \$100 per day up to the maximum stated in the Schedule of Benefits.

The period of Emergency Medical Reunion is not to exceed 10 days, including travel.

All transportation in connection with an Emergency Medical Reunion must be pre-approved and arranged by an assistance company representative appointed by the Company.

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses, subject to the Deductible Amount, [co-payment], and Coinsurance Percentage shown in the Schedule of Benefits, if any; for a Prescription Drug or medication when prescribed by a Physician on an outpatient basis.

Prescription Drug means a drug which:

- 1) Under Federal law may only be dispensed by written prescription; and
- 2) Is utilized for the specific purpose approved for general use by the Food and Drug Administration.

The Prescription Drug must be dispensed for the outpatient use by the Plan Participant:

- 1) On or after the Plan Participant's Effective Date; and
- 2) By a licensed pharmacy provider.

Benefits are payable up to the Maximum Benefit Amount shown on the Schedule of Benefits.

PART B: TRAVEL ARRANGEMENT BENEFITS

TRIP INTERRUPTION BENEFIT

Benefits will be paid, up to the Maximum Benefit Amount shown in the Plan Participant's Schedule of Benefits:

- a) to join the Plan Participant's Trip if the Plan Participant must depart after the Plan Participant's Scheduled Departure Date or travel via alternate travel arrangements by the most direct route possible to reach the Plan Participant's Trip destination; or
- b) to rejoin the Plan Participant's Trip or transport the Plan Participant to the Plan Participant's originally scheduled return destination, if the Plan Participant must interrupt the Plan Participant's Trip after departure, each by the most direct route possible.

Trip Interruption must be due to:

- 1) The Plan Participant's, or an Immediate Family Member's, death, which occurs while the Plan Participant is/are on the Plan Participant's Trip;

provided such circumstances occur while coverage is in effect.

EXCLUSIONS

The Plan Document does not cover any loss resulting from any of the following unless otherwise covered under the Plan Document by Additional Benefits:

- 1) Suicide, attempted suicide (including drug overdose) self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane;
- 2) War or any act of war, declared or undeclared;
- 3) An Accident which occurs while the Plan Participant is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;
- 4) Injury sustained while in the service of the armed forces of any country. When the Plan Participant enters the armed forces of any country, We will refund the unearned pro rata premium upon request;
- 5) Voluntary, active participation in a riot or insurrection;
- 6) Organ transplants;
- 7) Treatment for an Injury or Sickness resulting from the Plan Participant's intoxication or use of illegal drugs or any drugs or medication that is intentionally not taken in the dosage recommended by the manufacturer or for the purpose prescribed by the Plan Participant's Physician;
- 8) Commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal occupation;
- 9) Charges which are in excess of Usual, Reasonable and Customary charges;
- 10) Charges that are not Medically Necessary;
- 11) Charges provided at no cost to the Plan Participant;
- 12) Expenses incurred for treatment while in Your Home Country;
- 13) Expenses incurred for an Accident or Sickness after the Benefit Period shown in the Schedule of Benefits or incurred after the termination date of coverage;
- 14) Regular health checkups; routine physical, immunizations or other examination where there are no objective indications or impairment in normal health;
- 15) Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in an occupation for monetary gain from sources other than the Participating Organization;
- 16) Benefits for enrolling solely for the purpose of obtaining medical treatment, while on a waiting list for a specific treatment, or while traveling against the advice of a Physician;
- 17) Pre-existing conditions;
- 18) Pregnancy or childbirth, except when conception occurs while covered under the Plan Document; miscarriage resulting from an accident, elective abortion; elective cesarean section; or any complications of any of these conditions; pregnancy or childbirth or a dependent when dependent child of an Plan Participant (except for complications arising there from);
- 19) Drug, treatment or procedure that either promotes or prevents conception, or prevents childbirth, including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal thereof;
- 20) Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes;
- 21) Eyeglasses, contact lenses, hearing aids braces, appliances, or examinations or prescriptions therefore;

- 22) Injury sustained while taking part in: mountaineering; hang gliding; parachuting; bungee jumping; racing by horse, motor vehicle or motorcycle; scuba diving, involving underwater breathing apparatus, unless PADI or NAUI certified; water skiing; spelunking; parasailing; white water rafting;
- 23) Practice or play in any intercollegiate, professional or semiprofessional sports contest or competition;
- 24) Treatment of Mental and Nervous Disorders;
- 25) Elective or Cosmetic surgery and Elective Treatment or treatment for congenital anomalies (except as specifically provided), except for reconstructive surgery on a diseased or injured part of the body (Correction of a deviated nasal septum is considered cosmetic surgery unless it results from a covered Injury or Sickness);
- 26) Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from, except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private aircraft used for business or pleasure purposes.
- 27) Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste, from combustion of nuclear fuel, the radioactive, toxic, explosive or other hazardous properties of any nuclear assembly or nuclear component of such assembly;
- 28) Plan Participant being exposed to the Utilization of nuclear, chemical or biological weapons of mass destruction

CLAIM PROVISIONS

NOTICE OF CLAIM:

Written notice of death, or Injury or Sickness must be given to Us within 60 days after a Covered Loss occurs or begins or as soon as reasonably possible. Notice can be given to Our authorized licensed agent. Notice should include the Participating Organization's name and number and a Plan Participant's name and address.

If written notice is not received within 60 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 60 day period; and
- 2) it is further shown that notice was given as soon as possible.

CLAIM FORMS:

When We receive the notice of claim, We will send forms for filing proof of loss. If claim forms are not sent within 15 days after receipt of such notice, the Proof of Loss requirements stated below will be deemed to have been met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:

Written proof of loss must be furnished to Us in the case of a claim for loss for which the Plan Document provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to Us at intervals required by us.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 90 day period; and
- 2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS:

Benefits due under the Plan Document for a loss, other than a loss for which the Plan Document provides installments, will be paid within 30 days after Our receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for loss for which the Plan Document provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid within 30 days after Our receipt of a written proof of loss, unless otherwise stated in the Description of Benefits.

Failure to pay claims within 30 days shall entitle the claimant to interest at the rate of 9 per cent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. A claimant or their assignee shall be notified by Us of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim. Any required interest payments shall be made within 30 days after the payment.

PAYMENT OF CLAIMS:

All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of the Plan Document.

All other benefits will be paid to the Plan Participant suffering the loss. If the Plan Participant dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of the Plan Document.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to \$1,000 to a relative by blood or marriage whom We believe is equitably entitled. This good faith payment satisfies Our legal duty to the extent of that payment.

Any other accrued benefits which are unpaid at a Plan Participant's death may, at Our option, be paid either to his beneficiary or to his estate. All other benefits, unless specifically stated otherwise, will be paid to a Plan Participant.

DESIGNATION OR CHANGE OF BENEFICIARY:

Each Plan Participant may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order:

- 1) Beneficiaries designated in writing by the Plan Participant for the Plan Document on file with the Participating Organization, if any, otherwise;
- 2) Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Participating Organization, if any, otherwise;
- 3) In equal shares to the members of the first surviving class of those that follow, if any:
 - a) a Plan Participant's lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner;
 - b) a Plan Participant's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Plan Participant has or had legal guardianship (proof will be required); or
 - c) a Plan Participant's parents, whether natural, step or adoptive; or
 - d) a Plan Participant's Sisters or Brothers, otherwise.
- 4) The estate of the Plan Participant.

A Plan Participant may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Participating Organization. When a request for designation or change is received by the Participating Organization, it will take effect on the date of its execution, whether or not the Plan Participant is living on the date it is received by the Participating Organization. Any interest created by the request will be subject to any payment made or action taken before its receipt.

A Dependent's beneficiary is the Plan Participant. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Plan Participant's estate.

PHYSICAL EXAMINATION AND AUTOPSY:

We have the right to have a Physician of Our choice examine the Plan Participant as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death. We will pay the cost of the examination or autopsy.

RECOVERY OF OVERPAYMENT:

If benefits are overpaid, or paid in error, We have the right to recover the amount overpaid or paid in error by any of the following methods.

- 1) A request for lump sum payment of the amount overpaid or paid in error or
- 2) Reduction of any proceeds payable under the Plan Document by the amount overpaid or paid in error.

RECOVERY OF BENEFITS:

We reserve the right to recover from a Plan Participant any benefits We have paid to him for injuries:

- (1) Received in a covered Accident; and
- (2) Which are covered under:
 - (a) workers' compensation or similar statutory remedies available under law; or
 - b) Any employer's liability Insurance.

It will be assumed that the Plan Participant is in receipt of such benefits unless he gives us proof such benefits have been denied to him.

“Recovery” means monies paid to the Plan Participant through judgment, settlement or otherwise to compensate for all losses caused by the Injury.

RIGHT OF REIMBURSEMENT / SUBROGATION:

If a Plan Participant recovers expenses for Sickness or Injury that occurred due to the negligence of a third party, We have the right to first reimbursement for all benefits We paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the Plan Participant, the Plan Participant's parents if the Plan Participant is a minor, or the Plan Participant's legal representative as a result of that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the third party admits liability.

We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits We paid for that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

LEGAL ACTIONS:

No legal action may be brought to recover on the Plan Document within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:

The Plan Document, the application of the Participating Organization, a copy of which is attached, endorsements, riders, and the application or participation agreement with the Participating Organization] and attached papers constitute the entire contract between the parties. If an application of a Plan Participant is required, the application of any Plan Participant, at Our option, may also be made a part of this contract.

All statements made by the Participating Organization, or by a Plan Participant are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2-years from the Plan Participant's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

No change in the Plan Document will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Plan Document. No agent may change the Plan Document or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE:

The Plan Document is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

REPORTING REQUIREMENTS:

The Participating Organization or its authorized agent must report to us, by the premium due date:

- (1) The names of all Plan Participants on the Effective Date of the Plan Document;
- (2) The names of all persons who are Plan Participant after the Effective Date of the Plan Document;
- (3) The names of those persons whose insurance has terminated; and
- (4) Additional information required as agreed to by Us and the Participating Organization.

PLAN DOCUMENT TERMINATION:

We may terminate coverage on or after the anniversary of any premium due date. The Participating Organization may terminate its coverage on any premium due date. Written notice must be given at least 31 days prior to such premium due date.

CLERICAL ERROR:

Clerical error in keeping any records pertaining to the coverage, whether by the Participating Organization or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

ASSIGNMENT:

No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

INSOLVENCY:

The insolvency, Bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Participating Organization will not impose upon the Company any

liability other than the liability defined in the Plan Document. The insolvency of the Participating Organization will not make the Company liable to the creditors of the Participating Organization, including Plan Participants under the Plan Document.

WAIVER:

Failure of the Company to strictly enforce its rights under the Plan Document at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.