GROUP INBOUND TRAVEL INSURANCE PLAN DOCUMENT

POLICYHOLDER: Fairmont Specialty Trust

POLICYHOLDER ADDRESS: ITA BANK AND TRUST COMPANY LTD
Suite 4210, 2nd Floor Canella Court,
48 Market St,
Cayman Bay
PO Box 32203,
Grand Cayman KY1-1208,
Cayman Islands

PARTICIPATING ORGANIZATION

PLAN NUMBER: LF__________

EFFECTIVE DATE:

EXPIRATION DATE:

RATES:

The Plan Document is a legal contract between the Participating Organization and 100% by Advent, Lloyd’s Syndicate 780 (herein referenced as “the Company”).

The Company agrees to provide insurance, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in the Plan Document.

The Company and the Participating Organization have agreed to all the terms and conditions of the Plan Document.

The Plan Document and the coverage provided by it become effective at 12:01 A.M. at the address of the Participating Organization on the Plan Document Effective Date shown above. It continues in effect in accordance with the provisions set forth in the Plan Document.

THIS IS LIMITED BENEFIT COVERAGE.

READ IT CAREFULLY.

THE PLAN DOCUMENT IS NOT RENEWABLE.
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SCHEDULE OF BENEFITS

POLICYHOLDER: FAIRMONT SPECIALTY TRUST

PARTICIPATING ORGANIZATION: 

EFFECTIVE DATE: 

PLAN DOCUMENT NUMBER: LF__________

PREMIUM DUE DATE: 

PLAN DOCUMENT PERIOD: Effective Date through Expiration Date

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 and holds a current and valid passport.

Spouses of the above eligible Class who is considered to be a covered Class.

Natural or legally adopted Dependent unmarried children of an above eligible Class from the moment of birth and under 26 years of age who is considered to be a covered Class.

PART A: ACCIDENT AND SICKNESS BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Class 1 Principal Sum: Up to $10,000

Time Period for Loss: 364 days

Aggregate Limit: $1,000,000

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

Per Injury or Sickness Maximum Per Person,
Per Plan Year

$2,000,000

Deductible Per Plan Participant Per
Injury or Sickness:

Network Provider: $0
Non-Network Provider: $0 (Unless noted below)

Initial Treatment Period:

365 Days from the date of Injury or Sickness

Out-of-Pocket Maximum Per Plan Participant
Per Plan Term:

$2,500

Coinsurance:

In-Network: 100% of the Preferred Allowance
Out-of-Network: 80% of Usual, Reasonable & Customary (URC) Charges

Benefit Period:

52 weeks from the date of the Covered Sickness or Injury, provided the Expense occurs prior to the Expiration Date and care is Medically Necessary.

Terms of Payment

Coordination of Benefits

Any Deductibles, Coinsurance, Co-payments, Benefit Periods, and Benefit Maximums apply on a per Plan Participant per Covered Injury or Sickness basis.

<table>
<thead>
<tr>
<th>BENEFIT COVERAGE</th>
<th>BENEFIT AMOUNT</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>In-Network Provider Benefit</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Room &amp; Board Benefit:</td>
<td>100% of the Preferred Allowance, subject to a $100 copay</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>Intensive Care/Cardiac Care Unit Benefit</td>
<td>100% of the Preferred Allowance</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Miscellaneous Expense Benefit</td>
<td>100% of the Preferred Allowance</td>
</tr>
<tr>
<td>BENEFIT COVERAGE</td>
<td>BENEFIT AMOUNT</td>
</tr>
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<td>------------------------------------------------------</td>
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<tr>
<td></td>
<td>In-Network Provider Benefit</td>
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<tr>
<td>Surgeon (In or Outpatient) Benefits</td>
<td>100% of the Preferred Allowance</td>
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<tr>
<td>Pre-Admission Testing Benefit</td>
<td>100% of the Preferred Allowance</td>
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<tr>
<td>Anesthesia Benefit</td>
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<tr>
<td>Day Surgery Miscellaneous Benefit</td>
<td>100% of the Preferred Allowance, subject to a $100 copay</td>
</tr>
<tr>
<td>Diagnostic X-Ray and Lab Benefit</td>
<td>100% of the Preferred Allowance</td>
</tr>
<tr>
<td>Ambulance Benefit</td>
<td>100% of the Preferred Allowance</td>
</tr>
<tr>
<td>Physician Visit Benefit (Inpatient)</td>
<td>100% of the Preferred Allowance</td>
</tr>
<tr>
<td>Physician Visit Benefit (Outpatient)</td>
<td>100% of the Preferred Allowance, subject to a $20 copay</td>
</tr>
<tr>
<td>Consultant Physician Benefit</td>
<td>100% of the Preferred Allowance</td>
</tr>
<tr>
<td>Radiation/Chemotherapy Benefit</td>
<td>100% of the Preferred Allowance</td>
</tr>
<tr>
<td>Emergency Room Benefit</td>
<td>100% of the Preferred Allowance, subject to a $100 copay</td>
</tr>
<tr>
<td>Wellness Medical Benefit</td>
<td>100% of the Preferred Allowance, subject to a $20 copay</td>
</tr>
<tr>
<td>Maternity and Pre-Natal Care Expense Benefit</td>
<td>Covered as any other Sickness</td>
</tr>
<tr>
<td>(Conception must occur while covered under the Policy)</td>
<td></td>
</tr>
<tr>
<td>BENEFIT COVERAGE</td>
<td>BENEFIT AMOUNT</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td><strong>In-Network Provider Benefit</strong></td>
<td><strong>Out-of-Network Provider Benefit</strong></td>
</tr>
<tr>
<td>Home Country Benefit (up to a max of 90 days per 12 months of coverage on an approved vacation leave)</td>
<td>Covered as any other Sickness</td>
</tr>
<tr>
<td>MENTAL &amp; NERVOUS CONDITIONS EXPENSE BENEFIT</td>
<td>Covered as any other Sickness</td>
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<tr>
<td>In-Patient Expense</td>
<td>Covered as any other Sickness</td>
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<td>Out-Patient Expense</td>
<td>100% of the Preferred Allowance, subject to a $20 copay</td>
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<td>ALCOHOL &amp; DRUG ABUSE EXPENSE BENEFIT</td>
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<td>In-Patient Expense</td>
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<tr>
<td>Elective/Therapeutic Termination of Covered Pregnancy Benefit (Conception must occur while insured under the Plan)</td>
<td>Covered as any other Sickness</td>
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<tr>
<td>Emergency Dental Expense Benefit</td>
<td>Covered as any other Sickness</td>
</tr>
<tr>
<td>Emergency Dental Expense Benefit</td>
<td>100% of the Preferred Allowance, up to $500 maximum benefit, subject to a $20 co-pay</td>
</tr>
<tr>
<td>Palliative Dental</td>
<td>80% of URC, up to $500 maximum benefit, subject to a $20 co-pay</td>
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<tr>
<td>Physiotherapy Expense Benefit - Inpatient</td>
<td>100% of the Preferred Allowance</td>
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<tr>
<td>Physical Therapy – Outpatient, limited to one visit per day (See Description of Benefits for specific services)</td>
<td>80% of URC, limited to a maximum of 12 visits per plan year, per treatment, subject to a $20 copay per visit</td>
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<tr>
<td>Durable Medical Equipment Expense Benefit</td>
<td>100% of the Preferred Allowance</td>
</tr>
<tr>
<td></td>
<td>100% of URC</td>
</tr>
<tr>
<td><strong>Intramural, Club &amp; Athletic Sports</strong> (see policy Description of Benefits)</td>
<td>100% of Preferred Allowance</td>
</tr>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>COVERAGE</strong></th>
<th><strong>BENEFIT AMOUNT</strong></th>
</tr>
</thead>
</table>
| **OUT-PATIENT PRESCRIPTION DRUG EXPENSE BENEFIT** | Covered Percentage | Covered Percentage Out of Network:

| Covered Percentage: | 50% of Actual Charges | 50% of Actual Charges |
| Contraceptive Drugs and Devices | 100% of Preferred Allowance | 100% of URC |

**NOTES:**
- We do not pay benefits for the amount of Eligible Expenses paid by You as Your Coinsurance or Copay 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.
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 Sickness or Injury causing the Sickness or 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 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.

**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 a Sickness or 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 and holds a current and valid passport.

**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 and holds a current and valid passport.

**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 an 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. 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.

**Incidental Trip** means a trip to the Plan Participant’s Home Country for up to 90 days per 12 months of coverage.
**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 Teeth** means the major portion of the individual tooth which is present, regardless of filings and caps; and is not carious, abscessed, or defective.

**Network Provider** means a Physician, Hospital and other healthcare providers who have contracted to provide specific medical care at negotiated prices.

The availability of specific providers is subject to change without notice. You should always confirm that a Network Provider is participating at the time services are required by calling us at 1-800-899-4233 and/or by asking the provider when you make an appointment for services.

**Non-Network Provider** means a Physician, Hospital and other healthcare providers who have not agreed to any pre-arranged fee schedules. A Plan Participant may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Plan Participant’s responsibility.

**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 Terms. 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 and holds a current and valid passport.

**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 and holds a current and valid passport, and for whom proper premium payment has been made when due, and who is therefore a Plan Participant under the Plan Document.

**Policy** means this document, the Application of the Participating Organization 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.

**Policyholder** means the entity shown as the Policyholder in the Schedule of Benefits.

**Preferred Allowance** means the amount a Network Provider will accept as payment in full for Eligible Expenses.

**Pre-Existing Condition** means an Injury, Sickness, disease, or other condition during the 3-month period immediately prior to the date 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.

**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 Participating Organization or the Company.

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

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, Lloyd’s Syndicate 780 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.

A Plan Participant Person’s Dependent(s), as applicable, are eligible on the latest of the date:
1) the Plan Participant is eligible, if the Plan Participant has Dependents on that date; or
2) the date the person becomes a Dependent; or within 30 days of arrival into the US; or
3) the next Annual Open Enrollment (if applicable) following the date the person becomes a Dependent
   if the Newborn Children Coverage, Newborn Adopted Children Coverage or Adopted Children
   Coverage provisions do not apply.

If the Plan Participant is in a Class of Eligible Persons and is also eligible as a Dependent, He or She may
be Covered only once under the Plan Document. In no event will a Dependent be eligible if the Plan
Participant is not eligible.

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 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 his Home Country airspace; or
5) The Date requested by the Participating Organization.

Newborn Children Coverage: Coverage for a newborn Child will begin from the moment of birth. You
must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage
for the newborn Child will terminate upon the expiration of the initial 31 day period.

Newborn Adopted Children Coverage: In the case of adoption of a newborn Child, coverage will be on the
same basis as a newborn Child if a written agreement to adopt such Child has been entered into by You
prior to the birth of the Child, whether or not such agreement is enforceable.

Newborn Child Exception: This section does not apply to a newborn Child at that Child’s birth if the Child
is born to You while You are a Plan Participant as a Dependent under the Plan Document. Benefits for
Newborn Children apply only to a Child born to a Plan Participant or their Spouse.

Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the
date of placement in Your home for the purpose of adoption or the date of an entry of an interim court order
granting You temporary custody of the child, whichever comes first. A notice of placement for adoption
must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate
upon the expiration of the initial 31 day period.
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.

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;
2) The date the Participating Organization loses its entity by means of dissolution, merger, or otherwise;
3) The date the Participating Organization is eliminated as a Participating Organization by an amendment
to or change in the Plan Document;
4) The date ending the Coverage Month for which the last premium payment is made for the Participating
Organization's insurance;
5) The last day of a Coverage Month, if the Participating Organization has given the Company at least 30
calendar days prior written notice.

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 permanently 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 date the Participating Organization is no longer eligible to sponsor coverage under the Plan Document; or
12) The expiration date of the term of coverage, requested by the Participating Organization.

**Dependent’s Termination Date**
A Dependent’s coverage under the Plan Document ends on the earliest of:
1) The date the Plan Document terminates; or
2) The date the Plan Participant’s coverage ends; or
3) The date the Dependent is no longer a Dependent; or
4) The last day of the period for which premiums have been paid.
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 31 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. An increase in rates will not be made more than once in a 12 month period. 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.

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:

Coordination of Benefits Provision:

If a Plan Participant is covered for Benefits under the Plan Document, and is also covered for these Benefits under one or more other Plans, the benefits payable under the Plan Document will be coordinated with the benefits payable under all other Plans.

Coordination of Benefits will be used to determine the benefits payable for a Plan Participant for any Claim Determination Period if, for the Allowable Expenses incurred in that period, the sum of (1) and (2) below would exceed those Allowable Expenses:

1) The benefits that would be payable under the Plan Document without coordination; and
2) The benefits that would be payable under all other Plans without the coordination of benefits provisions in those Plans.

The benefits that would be payable under the Plan Document for Allowable Expenses incurred in any Claim Determination Period without Coordination of Benefits will be reduced to the extent required so that the sum of:

1) Those required benefits; and
2) All the benefits payable for those Allowable Expenses from all other Plans will not exceed the total of those Allowable Expenses.

Benefits payable under all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of the Plan Document are determined if:

1) The Benefit Determination Rules would require the Plan Document to determine its benefits before that Plan; and
2) The other Plan has a provision that coordinates its benefits with those of the Plan Document and would, based on its rules, determine its benefits after the Plan Document.
When Coordination of Benefits reduces the total amount otherwise payable in a Claim Determination Period for a Plan Participant, each benefit that would be payable in the absence of Coordination of Benefits will be reduced in proportion. The reduced amount will be charged against any applicable benefit limit of the Plan Document.

We reserve the right to release to or obtain from any other insurance company or other organization or person, any information that, in Our opinion, We or it needs for the purpose of the Coordination of Benefits.

When payments that should have been made under the Plan Document based on the terms of this provision have been made under any other Plans, We have the right to pay to any other organization making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered benefits paid under the Plan Document. We will be released from all liability under the Plan Document to the extent of these payments. When an overpayment has been made by us, at any time, We will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance company or organization, as We may determine.

**Benefit Determination Rules** - The rules below establish the order in which benefits will be determined:

1) **Benefits not as a Dependent:**
   The benefits of a Plan that covers the person for whom claim is made other than as a dependent will be determined before a Plan that covers that person as a dependent.

2) **Dependent Benefits under Different Parent Plans:**
   The benefits of a Plan that covers the person for whom claim is made as a dependent of the parent whose birthday falls earlier in the year will be determined before the benefits that covers that person as a dependent under the other parent’s Plan.

   When both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

   However, if the other Plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

   Notwithstanding the foregoing, in the case of a dependent child of divorced or separated parents, the following rules will apply:
   a) If there is a court decree that establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan that covers the child as a dependent of the parent so responsible will be determined before any other Plan, otherwise:
   b) The benefits of a Plan that covers the child as a dependent of the parent with custody will be determined before a Plan that covers the child as a dependent of a step-parent or a parent without custody;
   c) The benefits of a Plan that covers the child as a dependent of a step-parent will be determined before a Plan that covers the child as a dependent of the parent without custody.

3) **Benefits for Person Longest Covered:**
   When the above rules do not establish the order, the benefits of a Plan that has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time.

**Right to Receive and Release Necessary Information**
For this section to work, We must exchange information with other plans. To do so, We may give to or get from any source all such information necessary. This will be done without the consent of or notice to any person. Any people claiming Benefits under this plan must give to Us the required information.

Facility of Payment

Another plan may pay a Benefit that should be paid by Us by terms of this section. If this happens, We may pay to such payor the amount required for it to satisfy the intent of this section. Any amount so paid will be considered a Benefit under this plan. We will not be liable for such payment after it is made.

Whenever used in this provision:

Plan means any plan which provides Benefits or services for, or by reason of, Hospital, surgical, medical, or dental care, or treatment through:

1) Group, blanket or franchise insurance coverage;
2) Service plan contracts, group or individual practice or other prepayment plans;
3) Coverage under any labor management trustee plans, union welfare plans, employer organization plans, professional organizations, self-funded plans or employee benefit organization plans which provide medical or dental benefits or services; or
4) A government program, or statute, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;
5) Medicare (Title XVIII of the Social Security Act); and
6) Any part of a state auto reparation or indemnity act (no-fault insurance) with which the state permits coordination.

Plan does not include coverage under individual or family policies or contracts. Each Plan or part of a Plan that has a right to coordinate benefits will be considered a separate Plan.

This Plan means the medical care Benefits provided by the Plan Document.

Allowable Expense means any necessary, Usual, Reasonable and Customary item of expense, incurred while the person (for whom the claim is made) is Plan Participant, or is entitled to Benefits after insurance ends, under the Plan Document; and at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under the Plan Document.
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, 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;

   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.

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

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.

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 within 364 days after the date of the Eligible Expense.

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) **Hospice Care Benefit** as follows:

a) nursing care by a Registered Nurse; or a licensed practical Registered Nurse, a vocational Registered Nurse, or a public health Registered Nurse who is under the direct supervision of a Registered Nurse;

b) physical therapy and speech therapy when rendered by a licensed therapist;

c) medical supplies, including drugs and the use of medical appliances;

d) physician’s services; and

e) services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.
6) Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.

7) Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items.

8) Immunizations required for admittance to educational institution.

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 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.

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.

2) A Physician, for assistant surgeon duties up to the Maximum Benefit shown in the Schedule of Benefits.

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.

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.

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.

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.

**WELLNESS MEDICAL EXPENSE BENEFIT:**

We will pay Eligible Expenses, as per the limits stated in the Schedule of Benefits, Sickness Medical. Coverage is limited to the following expenses incurred subject to Exclusions. In no event will the Company’s maximum liability exceed the maximum stated in the Schedule of Benefits, as to expenses during any one period of individual coverage. Covered wellness expenses include:

1) Routine physical examinations
2) Preventive medical attention

**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 a 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 in 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.)

HOME COUNTRY ACCIDENT & SICKNESS MEDICAL BENEFIT

Those expenses specifically described above which are incurred within the Plan Participant’s Home Country during the Home Country Benefit Period, for a Covered Injury or Sickness that occurred, was diagnosed, and treated INSIDE the Plan Participant’s Home Country during an Incidental Trip to the Plan Participant’s Home Country. Covered Expenses as described above which are incurred in the Plan Participant’s Home Country are limited to the maximum stated in the Schedule of Benefits.

MENTAL AND NERVOUS CONDITIONS EXPENSE BENEFIT

If a Plan Participant requires treatment for a Mental or Nervous Condition, We will pay for such treatment as follows:

BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT

When a Plan Participant requires Hospital Confinement for treatment of a Mental or Nervous Condition, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement. Such confinement must be in a licensed or certified facility, including Hospitals.

BENEFITS FOR OUTPATIENT MENTAL AND NERVOUS SERVICES

We will pay the Covered Percentage of the Eligible Expenses incurred for the outpatient treatment of Mental and Nervous Conditions as defined up to one visit per day.

The Mental and Nervous Condition must, in the professional judgment of healthcare providers, be treatable, and the treatment must be Medically Necessary.

Outpatient treatment and Physician services include charges made by an outpatient treatment department of a Hospital, or community mental health facility, or charges for services rendered in a Physician’s office. Treatment may be provided by any properly licensed Physician, psychologist or other provider as required by law.

Biologically Based Mental Sickness means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Sickness.

We will pay the Covered Percentage of the Eligible Expenses incurred for treatment of biologically based mental Sickness, including:

a) Schizophrenia;

b) Schizoaffective disorder;

c) bipolar affective disorder;

d) major depressive disorder;
c) specific obsessive-compulsive disorder;
f) delusional disorders;
g) obsessive compulsive disorders;
h) anorexia and bulimia; and
i) panic disorder.

**ALCOHOL AND DRUG ABUSE EXPENSE BENEFIT**

If a Plan Participant requires treatment on account of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay for such treatment as follows:

**BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT**

When a Plan Participant is confined as an inpatient in: (i) a Hospital; or (ii) a Detoxification Facility for the treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement.

Such Confinement must be in a licensed or certified facility, including Hospitals.

**BENEFITS FOR OUTPATIENT ALCOHOL and DRUG SERVICES**

We will pay the Covered Percentage of the Eligible Expenses incurred for the treatment of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency.

Outpatient Treatment and Physician services include charges for services rendered in a Physician's office or by an outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the Hospital, community mental health facility or alcoholism treatment facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by or under the clinical supervision of a licensed Physician or a licensed psychologist who certifies that a Plan Participant needs to continue such treatment.

**Alcohol Abuse** means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

**Drug Abuse** means a condition that is characterized by a pattern of pathological use of a drug with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

**Detoxification Facility** means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social and emotional needs of the individual by:

a) monitoring the amount of alcohol and other toxic agents in the body of the individual;
b) managing withdrawal symptoms; and
motivating the individual to participate in the appropriate addictions treatment programs for Alcohol and Drug Abuse.

**ELECTIVE/THERAPEUTIC TERMINATION OF COVERED PREGNANCY BENEFIT**

We will pay benefits as described in the Schedule of Benefits for expenses incurred for the intentional termination of a covered pregnancy before the fetus can live independently.

**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.

**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 or following hospitalization and administered by a licensed physiotherapist as an inpatient or outpatient, 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.

ATHLETIC SPORTS & HAZARDOUS ACTIVITY BENEFIT

Coverage is provided up to the maximum amount payable as stated in the schedule if the Plan Participant’s Injury or Sickness results from the below enumerated Athletic Sports activities:

1) Intramural and Club Sports - resulting from: Baseball; Basketball; Cheerleading; Competitive Cycling (Road, Track, CX); Cross Country; Diving; Equestrian; Fencing; Field Hockey; Football (no Division One); Golf; Gymnastics; Ice Hockey; Lacrosse; Martial Arts; Polo Horse; Polo Water; Rugby; Skiing (Slalom, Giant Slalom, Downhill); Soccer; Softball; Swimming; Tennis; Track and Field; Volleyball; Wrestling.

• NOTE: Any Athletic Sport not expressly covered hereunder is excluded from this Plan Document unless the activity is non-contact and engaged in by You solely for leisure, recreation, entertainment, or fitness purposes only.

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.

EXTENSION OF ACCIDENT AND SICKNESS MEDICAL BENEFITS

If a Plan Participant is hospital confined at term of coverage, benefits will continue to be paid until the earlier of either discharge from the hospital they are confined to or until the maximum benefit has been paid, whichever occurs first. In no event will benefits continue beyond 90 days beyond the term of coverage.
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) War or any act of war, declared or undeclared;
2) 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;
3) 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;
4) Voluntary, active participation in a riot or insurrection;
5) Medical expenses resulting from a motor vehicle accident in excess of that which is payable under any other valid and collectible insurance;
6) Medical Treatment related to organ transplants, whether as donor or recipient; this includes expenses incurred for the evaluation process, the transplant surgery, post-operative treatment, and expenses incurred in obtaining, storing or transporting a donor organ. In relation to a bone marrow or stem cell transplant this exclusion would include harvesting & mobilization charges.
7) Commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal occupation;
8) Charges that are not Medically Necessary;
9) Expenses incurred, in excess of 90 days, for treatment while in Your Home Country;
10) Services or treatment rendered by a Physician, Registered Nurse or any other person who is employed or retained by the Participating Organization; or an Immediate Family member of the Plan Participant;
11) 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;
12) Expense incurred for treatment of temporomandibular joint (TMJ) disorders or craniomandibular joint dysfunction and associated myofacial pain;
13) Dental care or treatment other than care of teeth and gums required on account of Injury resulting from an Accident while the Plan Participant is covered under the Plan Document, and rendered within 6 months of the Accident;
14) Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore; unless directly resulting from an injury while covered under the policy.
15) Practice or play in any intercollegiate, professional or semiprofessional sports contest or competition;
16) Rest cures or custodial care;
17) 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);
18) Pre-existing conditions; however a Pre-Existing condition will be covered after the Plan Participant has been continuously insured for 3 months under the same insurance plan;
19) Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
a) While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or

Except as a fare paying passenger on a regularly scheduled commercial airline.

20) Transgender/Sexual Reassignment services, including, but not limited to: therapy, hormone therapy, surgeries.

21) 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.

22) 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 90 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 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.

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 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.

Complaints

Every effort is made to provide you with a high standard of service. However, occasionally disputes or misunderstandings can arise and you need to know what to do.

Claims: If you wish to make a complaint about a claim please contact your Claim Administrator as defined in your Evidence of Coverage or Plan Document.

Sales/ Policy Administration: If you wish to make a complaint about Sales/ Policy Administration (i.e. anything other than claims) please contact your Plan Administrator as defined in your Evidence of Coverage or Plan Document.

Further Steps

If you remain dissatisfied and are unable to resolve the situation you can also refer your complaint to the Complaints team at Lloyd’s at:

One Lime Street; London; EC3M 7HA; United Kingdom
Tel: +44 20 7327 5693         Fax: +44 20 7327 5225
Website: www.lloyds.com/complaints

Details of Lloyd’s complaints procedures are set out in a leaflet “Your Complaint – How We Can Help” available at www.lloyds.com/complaints and also available from the above address. If you remain dissatisfied after Lloyd’s has considered your complaint, you may have the right to refer your complaint to your local ombudsman or dispute resolution body. Alternatively you may be entitled to refer your complaint to the United Kingdom Financial Ombudsman Service; further details will be provided at the appropriate stage of the complaint process.
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.

RECORDS MAINTAINED:

The holder or its authorized administrator will maintain records of the essential features of each Plan Participant's insurance under the Plan Document.

We shall be permitted to examine the Participating Organization’s records relating to coverage under the Plan Document. Examination may occur at any reasonable time up to the later of:

(1) The two year period after the expiration of the Participating Organization's coverage; or
(2) The final adjustment and settlement of all claims under the Participating Organization's coverage.

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.
EVIDENCE OF COVERAGE:

An Evidence of Coverage of insurance will be delivered to the Participating Organization for delivery to each Plan Participant. Each Evidence of Coverage will list the benefits, conditions and limits of the Evidence of Coverage. It will state to whom the benefits will be paid.

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.

OTHER COVERAGE WITH US:

At any one time each Plan Participant may have only one Evidence of Coverage issued by Us having coverage similar to that described in the Plan Document. If we find He has more than one such Evidence of Coverage, coverage will be provided under the plan that has been in force for the longer period of time. We will refund premiums paid for all other Evidence of Coverages for concurrent periods of coverage.

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.