2020–2021 International Student Insurance Plan POLICY BROCHURE

TSU

TEXAS SOUTHERN UNIVERSITY

POLICYHOLDER:	**Texas Southern University**
POLICY NUMBER:	**CC002303**
EFFECTIVE DATE:	**August 11, 2020**
EXPIRATION DATE:	**August 10, 2021**

Please keep this Brochure as a brief description of the important features of the plan. It is not a contract of insurance. This plan includes both insurance and non-insurance benefits. The terms and conditions of coverage are set forth in the Plan issued to ITA Global Trust, LTD. For a detailed plan description, exclusions, and limitations please view the plan on file with your school. The Policy contains a complete description of all of the terms, conditions, and exclusions of the insurance plan as underwritten by Crum & Forster SPC. The Policy will prevail in the event of any discrepancy between this Brochure and the Policy.

By applying for this insurance you become a member of ITA Global Trust, LTD.

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PATIENT PROTECTION AND AFFORDABLE CARE ACT ("PPACA") DISCLOSURE STATEMENT

This insurance is not subject to, and does not provide certain insurance benefits required by the United States' Patient Protection and Affordable Care Act ("PPACA"). PPACA requires certain US citizens or US residents to obtain PPACA compliant health insurance, or "minimum essential coverage." PPACA also requires certain employers to offer PPACA compliant insurance coverage to their employees. Tax penalties may be imposed on U.S. residents or citizens who do not maintain minimum essential coverage, and on certain employers who do not offer PPACA compliant insurance coverage to their employees. In some cases, certain individuals may be deemed to have minimum essential coverage under PPACA even if their insurance coverage does not provide all of the benefits required by PPACA. You should consult your attorney or tax professional to determine whether this policy meets any obligations you may have under PPACA.

THIS IS LIMITED BENEFIT SHORT DURATION COVERAGE. READ IT CAREFULLY. THE POLICY IS NOT RENEWABLE.

ELIGIBILITY

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, having has his or her true, fixed and permanent home and principal establishment outside of the United States, and holds a current and valid passport.

Class 2. Spouses of the above eligible Class who is considered to be a covered Class and whose Application has been accepted by the Company.

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 and whose Application has been accepted by the Company.

Persons eligible to be a Plan Participant under the Policy are those persons described above. This includes anyone who may become eligible while the Policy 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
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 Policy. In no event will a Dependent be eligible if the Plan Participant is not eligible.

POLICY EFFECTIVE DATE

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

Plan Participant's Effective Date

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

1. The Effective Date of the Policy;
2. The date the Company receives a completed application or enrollment form;
3. The day the Plan Participant becomes eligible, subject to any required waiting period, according to the referenced date requested and shown in the Application/Enrollment Form;
4. The moment the Plan Participant exits their Home Country airspace;
5. The Date the Company approves the Application; or
6. 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.

POLICY TERMINATION DATE

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

The Policy terminates automatically on the earlier of:

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

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

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

The Policyholder and the Company may terminate the Policy at any time by written mutual consent.

Plan Participant's Termination Date

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

1. The date the Plan Participant is no longer in an Eligible Class;
2. The date the Plan Participant returns to his or her Home Country;
3. The expiration of 364 days from the Effective Date of Coverage;
4. The date shown on the Evidence of Coverage issued by the Company;
5. The date the Plan Participant becomes a permanent resident of the United States;
6. The date the Plan Participant 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 Policy.

   This does not include Reserve or National Guard duty for training;
7. The end of the period for which the last premium contribution is made;
8. The date the Policy is terminated;
9. The date the Plan Participant requests, in writing, that his/her coverage be terminated;
10. The date the Plan Participant's participation in the Program terminates;
11. The date the Plan Participant's Trip is completed;
12. The date the Participating Organization is no longer eligible to sponsor coverage under the Policy;
13. The expiration date of the term of coverage, requested by the Participating Organization; or
14. The end of the Benefit Period shown in the Schedule of Benefits.

POLICY TERMINATION DATE *(continued)*

Dependent's Termination Date

A Dependent's coverage under the Policy ends on the earliest of:

1. The date the Policy terminates;
2. The date the Plan Participant's coverage ends;
3. The date the Dependent is no longer a Dependent;
4. The last day of the period for which premiums have been paid; or
5. The end of the Benefit Period shown in the Schedule of Benefits.

FULL EXCESS MEDICAL EXPENSES

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

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

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

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

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

SCOPE OF COVERAGE

Benefits are payable under the Policy 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 a 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 Policy 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 Policy.

SCHEDULE OF BENEFITS

ACCIDENT AND SICKNESS BENEFITS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Per Injury or Sickness Maximum for all Medical Expenses	$500,000	
Deductible Per Plan Participant Per Policy Term *The Deductible will be waived when treatment is rendered at the Student Health Center.*	$100	$500
Initial Treatment Period	90 Days from the date of Injury or Sickness	
Coinsurance	80% of Preferred Allowance	70% of Usual, Reasonable & Customary (URC)
Benefit Period:	From the date of the Covered Sickness or Injury, provided the Injury or Sickness occurs prior to the Expiration Date and care is Medically Necessary and while the Policy is in force.	
Terms of Payment	Full Excess	
Accidental Death and Dismemberment Benefits	Principal Sum: $10,000; Aggregate Limit: $500,000 Time Period for Loss: 365 Days	
Any Deductibles, Coinsurance, Co-payments, Benefit Periods, and Benefit Maximums apply on a per Plan Participant per Occurrence basis.		
BENEFIT COVERAGE	**BENEFIT AMOUNT**	
Hospital Services	**In-Network Provider**	**Out-of-Network Provider**
Hospital Room & Board Benefit	80% of Preferred Allowance $100 Copay per Visit	70% of Semi-Private Room Rate $100 Deductible per Visit*
Intensive Care/Cardiac Care Unit Benefit	80% of Preferred Allowance	70% of URC
Hospital Miscellaneous Expense Benefit	80% of Preferred Allowance	70% of URC
Surgeon (In or Outpatient) Benefits	80% of Preferred Allowance	70% of URC
Assistant Surgeon Benefit	80% of Preferred Allowance	70% of URC
Pre-Admission Testing Benefit	80% of Preferred Allowance	70% of URC
Anesthesia Benefit	80% of Preferred Allowance	70% of URC
Day Surgery Miscellaneous Benefit	80% of Preferred Allowance	70% of URC
Diagnostic X-Ray and Lab Benefit	80% of Preferred Allowance	70% of URC
Ambulance Benefit	80% of Preferred Allowance	70% of URC
Physician Visit Benefit (Inpatient)	80% of Preferred Allowance	70% of URC
Outpatient Services	**In-Network Provider**	**Out-of-Network Provider**
Physician Visit Benefit (Outpatient)	80% of Preferred Allowance $30 Copay Per Visit	70% of URC $30 Deductible Per Visit*
Consultant Physician Benefit	80% of Preferred Allowance	70% of URC
Radiation/Chemotherapy Benefit	80% of Preferred Allowance	70% of URC
Emergency Room Benefit	80% of Preferred Allowance $200 Copay Per Visit	80% of URC $200 Deductible Per Visit*
Wellness Medical Benefit	100% of the Preferred Allowance, up to a Maximum of $1,000 per Policy Term	No Benefit
Pregnancy	80% of Preferred Allowance	70% of URC
Maternity and Prenatal Care Expense Benefit	80% of Preferred Allowance	70% of URC
Elective Termination of Pregnancy Benefit *Up to $1,000 Maximum per Visit*	80% of Preferred Allowance	70% of URC
Diabetes Treatment Expense Benefit	80% of Preferred Allowance	70% of URC

* *Visit Deductible is in addition to the $500 Policy Term Deductible.*

SCHEDULE OF BENEFITS *(continued)*

Outpatient Services (continued)	In-Network Provider	Out-of-Network Provider
Emergency Dental Expense Benefit *Up to $100 per Tooth, $500 Maximum per Injury*	80% of Preferred Allowance	70% of URC
Durable Medical Equipment Expense Benefit	80% of Preferred Allowance	70% of URC
Skilled Nursing Facility Benefit	80% of Preferred Allowance	70% of Semi-Private Room Rate
Athletic Sports Activity Benefit *Up to a Maximum of $10,000 per Injury*	80% of Preferred Allowance	70% of URC
Mental & Nervous Conditions Expense Benefit	**In-Network Provider**	**Out-of-Network Provider**
Inpatient Expense *30 Days Maximum Per Policy Term*	80% of Preferred Allowance	70% of URC
Outpatient Expense *30 Visits Maximum Per Policy Term*	80% of Preferred Allowance $20 Copay Per Visit	70% of URC $20 Deductible Per Visit*
Alcohol & Drug Abuse Expense Benefit	**In-Network Provider**	**Out-of-Network Provider**
Inpatient Expense *30 Days Maximum Per Policy Term*	80% of Preferred Allowance	70% of URC
Outpatient Expense *30 Visits Maximum Per Policy Term*	80% of Preferred Allowance $20 Copay Per Visit	70% of URC $20 Deductible Per Visit*
Prescription Drugs	**In-Network Provider**	**Out-of-Network Provider**
Outpatient Prescription Drugs *Copays are per prescription based on a 30-day supply.* *Southern Scripts is the In-Network Pharmacy Benefits Manager.*	Copays: $20 Generic Drugs $50 Brand Name Preferred Drugs $75 Brand Name Non-Preferred Drugs	No Benefit
Non-Insurance Benefits *Benefits listed below are not insurance and are not affiliated with Crum & Forster, SPC. These services are provided by On Call International. Please see page 18 for further information.*		
Emergency Medical Evacuation	$50,000 Maximum Benefit	
Repatriation of Remains	$50,000 Maximum Benefit	
Family Reunion Benefit	$5,000 Maximum Benefit	

* *Visit Deductible is in addition to the $500 Policy Term Deductible.*

Benefits are provided for eligible Insured Persons. Terms and conditions are briefly outlined in this summary of coverage. Complete provisions pertaining to this insurance are contained in the policy underwritten by Crum and Forster, SPC. In the event of any conflict between this summary of coverage and the policy, the policy will govern. The policy is a short-term limited duration policy renewable only at the option of the insurer. This is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the Plan issued to your school. For a detailed plan description, exclusions, and limitations please view the plan on file with your school. 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 US residents and citizens obtain PPACA compliant insurance coverage. This plan is not designed to cover US residents and citizens. This policy is not subject to guaranteed issuance or renewal. PPO Networks are not provided by Crum & Forster, SPC.

Notice For further information on this Plan, please contact WebTPA at **(800) 407-0620** or email ***helpme@webtpa.com.***

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

If, within one year from the date of an Accident or Injury covered by the Policy, 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 Benefits.

Benefits are payable if such Injury: occurs during the course of time the Plan Participant is covered under the Policy, provided that this Insurance will not apply while such Plan Participant is riding in any civilian or military aircraft, unless previously consented to in writing by the Company.

Schedule of Covered Losses	Benefit (% of Principal Sum)
Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing (both ears)	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Speech	50%
Loss Hearing (both ears)	50%
Loss of Thumb and Index Finger of the Same Hand	25%

Aggregate Limit

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 the Policy 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.

Definitions

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 speech means total, permanent and irrecoverable loss of audible communication.

Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any 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.

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS

We will pay Accident or Injury 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 or Injury 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 365 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 7 days of the testing.
3. Nursing Services: Outpatient Charges for nursing services by a Registered Nurse or Licensed Professional.
4. Skilled Nursing Facility: Charges for services as described in the schedule of benefits. The benefit provides skilled nursing 24 hours a day, seven days a week, under the supervision of a registered nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A SNF provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence.

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

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.

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS *(continued)*

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.

ASSISTANT SURGEON BENEFIT

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

PRE-ADMISSION TESTING BENEFIT

We will pay benefits for charges for Pre-admission testing (inpatient confinement must occur within 7 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 Injury or Sickness indicated in the Schedule of Benefits. Outpatient x-ray services and laboratory tests are limited to the amount shown in the Schedule of Benefits.

AMBULANCE BENEFIT

When, by reason of Injury or Sickness, a Plan Participant requires the use of a community or Hospital Ambulance in a Medical Emergency, We will pay a Benefit Amount up to a Maximum shown in the schedule, within the metropolitan area in which the Plan Participant is located at that time the service is used. Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, the scene of the Accident or Medical Emergency to a Hospital or between Hospitals. Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area.

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS *(continued)*

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 Eligible expenses incurred.

RADIATION/ CHEMOTHERAPY THERAPY EXPENSE BENEFIT

We will pay the Covered Percentage for the Eligible 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 Injury 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

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS *(continued)*

Benefits, as to expenses during any one period of individual coverage. Covered wellness expenses include:

1. Routine physical examinations: per Plan term which includes, one routine physical examination, laboratory tests, x-rays and any other medical expense related to the examination.
2. Preventive medical attention: includes, annual Screening Mammogram for women; an annual cervical screening for women; a gynecological exam for women; Immunizations; Contraceptive Devices; Colorectal screening for adults over 50, an annual standard prostate diagnostic examination including, but not limited to, a digital rectal examination prostate-specific antigen test for men: (1) age fifty and over who are asymptomatic; and (2) age forty and over with a family history of prostate cancer or other prostate cancer risk factors.

PREGNANCY BENEFIT

Pregnancy coverage includes inpatient Hospital care following delivery in accordance with the guidelines recommended by the American Academy of Pediatrics and the American College of OB/GYNs, which is a minimum of 48 hours following a vaginal delivery or a minimum of 96 hours following a caesarean section. A decision to shorten the length of stay may be made by the attending physician in consultation with the patient.

1. Newborns: A newborn child of an Insured Student is automatically covered from the moment of birth for 31 days.
2. Routine well baby care includes Eligible expenses for:
    a. Hospital room and board (or nursery) charges;
    b. Routine Doctor visits while Hospital confined; and
    c. Circumcision while Hospital confined.
3. Care for a sick newborn child of an Insured Student includes Eligible expenses which are due directly to Bodily Infirmity or Injury, premature birth, or a congenital condition which exists at birth.

MATERNITY AND PRE-NATAL CARE BENEFIT

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

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

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the Plan Participant Person's attending Physician determines further Inpatient postpartum care 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;

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS *(continued)*

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.

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.)

DIABETES TREATMENT EXPENSE BENEFIT

We cover charges for the following Medically Necessary diabetes equipment services and supplies for the treatment of diabetes, when recommended by a Doctor or other licensed health care provider. We treat such charges the same way We treat any other Eligible expenses for a Sickness. Such supplies include: blood glucose monitors, blood glucose monitors for the legally blind, data management systems, test strips for glucose monitors and visual reading, urine test strips, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices or oral agents for controlling blood sugar. We also cover charges for expenses incurred for diabetes self-management education.

Coverage for self-management education and education relating to diet shall be limited to Medically Necessary visits upon the diagnosis of diabetes, where a Doctor diagnoses a significant change in the Covered Person's symptoms or conditions which necessitates changes in a patient's self-management or upon determination that reeducation or refresher education is necessary. Diabetes self-management education may be provided by a Doctor or other licensed healthcare provider, the Doctor's office staff, as part of an office visit, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian registered dietitian. Education may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet includes Medically Necessary home visits.

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

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS *(continued)*

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: Schizophrenia; Schizo-affective disorder; Bipolar affective disorder; Major depressive disorder; Specific obsessive-compulsive disorder; Delusional disorders; Obsessive compulsive disorders; Binge eating, anorexia and bulimia; and 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:

1. 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.
2. 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
c. Motivating the individual to participate in the appropriate addictions treatment programs for Alcohol and Drug Abuse.

ELECTIVE TERMINATION OF PREGNANCY BENEFIT

We will pay benefits as described in the Schedule of Benefits for expenses incurred for the intentional termination of 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 sustaining an Injury to natural teeth. We will pay benefits as described in the Schedule of Benefits for expenses incurred during the Plan Participant's Trip for emergency

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS *(continued)*

dental treatment. Only expenses for emergency dental treatment to natural teeth incurred during the Trip will be reimbursed. Expenses incurred after the Trip are not covered.

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 , up to up to the maximum amount shown in the Schedule of Benefits per day for the 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 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 Athletic Sports activities.

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 on or after the Plan Participant's Effective Date; and by a licensed pharmacy provider.

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

EXCLUSIONS

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

1. Suicide, attempted suicide (including drug overdose) self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared, any Terroristic Act.
3. Any Covered Loss which occurs while the Plan Participant is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps.
4. Any Covered Loss sustained while in the service of the armed forces of any country. When the Plan Participant enters the armed forces of any country, We will refund the unearned pro rata premium upon request.
5. Voluntary, active participation in a riot or insurrection.
6. Medical expenses resulting from a motor vehicle accident in excess of that which is payable under any other valid and collectible insurance.
7. 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.
8. For any Covered Losses resulting from the Plan Participant's intoxication or use of illegal drugs or any drugs or medication that is intentionally not taken in the dosage recommended by the manufacturer or for the purpose prescribed by the Plan Participant's Physician.
9. Commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal occupation.
10. Eligible Expenses for which the Plan Participant would not be responsible in the absence of the Policy.
11. Charges which are in excess of Usual, Reasonable and Customary charges.
12. Charges that are not Medically Necessary.
13. Charges provided at no cost to the Plan Participant.
14. Expenses incurred for an Accident or Injury or Sickness after the Benefit Period shown in the Schedule of Benefits or incurred after the termination date of coverage.
15. Regular health checkups; routine physical, immunizations or other examination where there are no objective indications or impairment in normal health; unless specifically covered by the Policy.
16. Services or treatment rendered by a Physician, Registered Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family member of the Plan Participant.
17. Duplicate services actually provided by both a certified nurse midwife and Physician.
18. Any Covered Loss 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 Policyholder.
19. Benefits for enrolling solely for the purpose of obtaining medical treatment, while on a waiting list for a specific treatment, or while traveling against the advice of a Physician.
20. Pre-existing conditions; however a Pre-Existing condition will be covered after the Plan Participant has been continuously insured for 6 months under the same Participating Organization.
21. Drug, treatment or procedure that either promotes or prevents childbirth, including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal thereof.

EXCLUSIONS
(continued)

22. Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes.
23. Expense incurred for treatment of temporomandibular joint (TMJ) disorders or craniomandibular joint dysfunction and associated myofacial pain.
24. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore; unless specifically covered by the Policy.
25. Weak, strained or flat feet, corns, calluses, or toenails.
26. Private-duty nursing services.
27. Expenses payable under any prior policy which was in force for the person making the claim.
28. Treatment paid for or furnished under any other individual or group policy, or other service or medical pre-payment plan arranged through the employer to the extent so furnished or paid, or under any mandatory government program or facility set up for the treatment without cost to any individual.
29. Travel in or upon: (a) a snowmobile; (b) a water jet ski; (c) any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel; (d) any off road motorized vehicle not requiring licensing as a motor vehicle.
30. Injury sustained while taking part in: mountaineering; hang gliding; parachuting; bungee jumping; racing by horse, motor vehicle or motorcycle; snowmobiling; motorcycle/motor scooter riding; scuba diving, involving underwater breathing apparatus, unless PADI or NAUI certified; scuba diving, involving underwater breathing apparatus; snorkeling; water skiing; snow skiing; spelunking; parasailing; white water rafting; surfing, unless part of a school credit course; and snow boarding.
31. Practice or play in any professional sports contest or competition.
32. Rest cures or custodial care.
33. Weight reduction programs or surgical treatment of obesity treatment of venereal disease.
34. 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).
35. Travel or flight in or on, including boarding or alighting from, any vehicle for aerial navigation:
    a. While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
    b. While being used for any test or experimental purpose; or
    c. While piloting, operating, learning to operate or serving as a member of the crew thereof; or
    d. While traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Plan Participant or any member of his household; or
    e. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
    f. An ultra light, hang gliding, parachuting or bungi-cord jumping.
36. 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.
37. Plan Participant being exposed to the utilization of nuclear, chemical or biological weapons of mass destruction.
38. Treatment of HIV infection, HIV related illness and AIDS (acquired immune deficiency syndrome) in excess of a lifetime maximum of $7,500.

DEFINITIONS

For the purposes of the Policy the capitalized terms used herein are defined as follows (additional terms may be defined within the provision to which they apply). Please see the Policy for a complete list of Definitions.

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.

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

Child(ren) 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.

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 Policy, 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.

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 C&F Cayman SPC on and behalf of ITI SP. Also hereinafter referred to as We, Us and Our.

Complications of Pregnancy means a condition which:

1. 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.
2. 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.

Copayment or Copay means a specified charge that the Plan Participant is required to pay when a medical service is rendered.

DEFINITIONS
(continued)

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

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

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

Deductible means the dollar amount of Covered Expenses which must be incurred, as applicable, and paid by the Covered Person before benefits are payable under the Policy. The Deductible may apply to each Covered Person or each Policy Term, as shown in the Schedule of Benefits.

Dependent means a Plan Participant's:

1. Lawful spouse, if not legally separated or divorced, 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.

Elective Treatment and Procedures means any Medical Treatment or surgical procedure that is not medically necessary, including any service, treatment, or supplies that are deemed by the federal, or a state or local government authority, or by the Company to be research or experimental or that is not recognized as a generally accepted medical practice.

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

Emergency/ Emergency Treatment 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:

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

Experimental or 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;

DEFINITIONS
(continued)

- 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.

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

Home Country means the country where a Plan Participant has his or her true, fixed and permanent home and principal establishment, holds a current and valid passport, and to which he or she has the intention of returning.

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 a Eligible Expense under the Policy.

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.

DEFINITIONS
(continued)

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, 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 any bodily harm that results, directly and independently of all other causes, from a covered Accident. To be covered, the Injury must first be treated while the Covered Person is insured under the Policy. A Sickness is not an Injury.

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

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.

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.

DEFINITIONS
(continued)

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.

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.

Non-Network Provider means a Physician, Hospital and other healthcare providers who have not agreed to any prearranged 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.

Outpatient means an 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.

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 or Physiotherapy 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 who is a Non-United States Citizen traveling outside their Home Country, has his or her true, fixed and permanent home and principal establishment outside of the United States, and for whom proper premium payment has been made when due, and who is therefore a Plan Participant under the Policy.

Policy means this document, the Master Application of the Policyholder and the Participating Organization and any end endorsements, riders or amendments that will attach during the Period of Coverage.

Policy Period means the period of time following the Policy'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 6-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 Complications of Pregnancy.

DEFINITIONS *(continued)*

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

Spouse means lawful spouse, if not legally separated or divorced, or Civil Partner

Surgical Procedure 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.

Usual and Customary Charge (URC) 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 Policy to describe expense will be considered to mean the percentile of the payment system in effect at Policy issue as shown on the Schedule of Benefits

We, Our, Us means C&F Cayman SPC on and behalf of ITI SP.

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

HOW TO FILE A CLAIM

In the event of an Accident or Sickness:

1. Seek appropriate treatment from a Physician, Hospital, or Urgent Care facility.
2. Show the provider your insurance ID Card and pay any required Copay or Deductible.
3. After treatment, the provider will submit the charges to the insurance company. The insurance company will pay the provider the agreed upon amount, as outlined in the Schedule of Benefits. The Company will issue you a statement, called an *Explanation of Benefits*, detailing what charges were paid.
4. After the insurance company has paid their share of charges, you will receive a billing statement from the provider(s) with the amount you owe. This is your responsibility to pay.
5. To view your claim status, log on to ***WebTPA.com***. You will need to register the first time you log on. After you are registered, you can check your claim status 24/7. You can also call **(800) 407-0620** or email ***helpme@webtpa.com***.
6. In rare cases, you may be asked to pay for services up front then submit a claim for reimbursement. If that is the case, send a completed claim form, along with the full provider billing statement and receipts detailing the payments you made to the following address:

   WebTPA
   PO Box 2415
   Grapevine, TX 76099-2415

   Before mailing, please make sure to:

   - Include your name, address, and phone number.
   - Include a photocopy or scan of your insurance ID Card.
   - Make copies of all statements and receipts for your records.

CLAIM PROVISIONS

Notice of Claim

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

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

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

Proof of Loss

Written proof of loss must be furnished to Us in the case of a claim for loss for which the Policy 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.

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 Policy.

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 Policy.

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.

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 Policy by the amount overpaid or paid in error.

ADDITIONAL POLICY PROVISIONS

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.

Privacy Statement

We know that Your privacy is important to You and we strive to protect the confidentiality of Your non-public personal information. We do not disclose any non-public personal information about our insureds or former insureds to anyone, except as permitted or required by law. We maintain appropriate physical, electronic and procedural safeguards to ensure the security of Your non-public personal information. You may obtain a detailed copy of our privacy policy by calling us toll-free at (800) 727-7642 or by visiting us at specialmarkets.com.

Complaints

In the event that You remain dissatisfied and wish to make a complaint You can do so by contacting us at specialmarkets.com.

Data Protection

Please note that sensitive health and other information that You provide may be used by us, our representatives, the insurers and industry governing bodies and regulators to process Your insurance, handle claims and prevent fraud. This may involve transferring information to other countries (some of which may have limited, or no data protection laws). We have taken steps to ensure Your information is held securely.

Where sensitive personal information relates to anyone other than You, You must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use as set out above.

Information we hold will not be shared with third parties for marketing purposes. You have the right to access Your personal records.

GLOBAL ASSISTANCE SERVICES

Global Assistance Services are provided by On Call International separately from the benefits provided by the Company under the Policy described in this brochure. These benefits are not insurance and are not provided by Crum & Forster, SPC. Global Assistance Services must be arranged by On Call; no claims for reimbursement of transportation will be considered. See the On Call Plan Description for full terms and Conditions of the services and benefits offered by On Call.

Description of Services

This plan provides the services and benefits you need to prepare for your destination as well as to help you with any problems you encounter while you are traveling or on assignment.

Contact the Global Response Center if you experience a medical, personal, travel, or safety problem or crisis. On Call provides access to immediate support should you experience any challenges when you are traveling.

Services and Benefits

Full terms, conditions and exclusions to coverage apply; review the full plan description carefully. This is only an outline of services. Please read the Description of Services for full details.

Benefit	Limit Per Insured Person, Per Insured Event
Medical Evacuation/ Repatriation	$50,000
Repatriation of Remains or Burial	$50,000
Emergency Reunion	$5,000 when Hospitalized for more than 3 days

How to Contact On Call

If you need Medical, Security or Travel assistance, regardless of the nature or severity of your situation, contact On Call 24 hours a day:

- Call toll-free from the U.S. or Canada:**+1 (844) 884-0958**
- Call collect from anywhere in the world: **+1 (603) 952-2661**
- Email us from anywhere in the world: **mail@oncallinternational.com**