2022-2023 | PLAN BENEFIT BROCHURE

PURMIT

Public Universities Risk Management & Insurance Trust

Serviced By:

Gallagher

Accident & Sickness Insurance Plan

Underwritten by:
Allied World Assurance Company

Policy Number:
CC008201

GROUP INBOUND TRAVEL INSURANCE POLICY

POLICYHOLDER: **Fairmont Specialty Trust**

POLICYHOLDER ADDRESS: ITA Global Trust, LTD
Suite 4210, 2nd Floor Canella Court,
48 Market St,
Camana Bay
PO Box 32203,
Grand Cayman KY1-1208,
Cayman Islands

PARTICIPATING ORGANIZATION: Public Universities Risk Management & Insurance Trust (PURMIT)

EFFECTIVE DATE: September 1, 2022

EXPIRATION DATE: August 31, 2023

UMR: B115R180022

The Policy is a legal contract between the Policyholder and Crum & Forster SPC for and on behalf of ITI SP (herein referenced as "the Company").

This Policy is issued by Crum & Forster SPC for and on behalf of ITI SP to the Fairmont Specialty Trust located in the Cayman Islands.

This Policy is not subject to U.S. jurisdiction.

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 Policy.

The Company and the Policyholder have agreed to all the terms and conditions of the Policy. The Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Policyholder on the Policy Effective Date shown above. It continues in effect in accordance with the provisions set forth in the Policy.

THIS IS LIMITED BENEFIT SHORT DURATION COVERAGE.

READ IT CAREFULLY.

THE POLICY IS NOT RENEWABLE.

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The following provisions appear within the Policy in the following order:

SCHEDULE OF BENEFITS

POLICYHOLDER: FAIRMONT SPECIALTY TRUST

PARTICIPATING ORGANIZATION: Public Universities Risk Management & Insurance Trust (PURMIT)

EFFECTIVE DATE:	9/01/2022
POLICY NUMBER:	CC008201
UMR:	B115R180022
PREMIUM DUE DATE:	Monthly in advance on the 1st of each month
POLICY PERIOD:	September 1, 2022 through August 31, 2023

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 who 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 are 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.

PART A: ACCIDENT AND SICKNESS BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Class 1 Principal Sum:	$5,000
Class 2 Principal Sum:	$5,000
Time Period for Loss:	365 days
Aggregate Limit:	$1,000,000

Loss of:	**Benefit: Principal Sum**
Loss of Life	$5,000
Loss of Both Hands	$5,000
Loss of Both Feet	$5,000
Loss of Entire Sight of Both Eyes	$5,000
Loss of One Hand and One Foot	$5,000
Loss of One Hand and Entire Sight of One Eye	$5,000
Loss of One Foot and Entire Sight of One Eye	$5,000
Loss of One Hand	$2,500
Loss of One Foot	$2,500
Loss of Entire Sight of One Eye	$2,500
Loss of Thumb and Index Finger of the Same Hand	$1,250

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 for all Injury and Sickness Medical Expenses: $3,000,000

Deductible Per Plan Participant Per Policy Term: Network Provider: $100

Non-Network Provider: $500

The Copays and Deductibles will be waived when treatment is rendered at the Student Health Center.

Out-of-Pocket Maximum Per Plan Participant Per Policy Term: Network Provider: Single - $3,000
Family - $6,000

Non-Network Provider: Single - $7,000
Family -$14,000

Coinsurance: In-Network: 90% of the Preferred Allowance

Out-of-Network: 70% of Usual, Reasonable & Customary (URC) Charges

Benefit Period: 52 weeks 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.

Terms of Payment: Full Excess

After the Deductible has been satisfied, benefits will be paid as listed below for the Provider selected.

BENEFIT COVERAGE	**BENEFIT AMOUNT**	
	In-Network Provider	**Out-of-Network Provider**
Hospital Room & Board Benefit:	90% of the Preferred Allowance, after a $50 copay per admission	70% of the Semi-Private Room Rate, after a $50 deductible per admission
Intensive Care/Cardiac Care Unit Benefit	90% of the Preferred Allowance	70% of URC
Hospital Miscellaneous Expense Benefit	90% of the Preferred Allowance	70% of URC

BENEFIT COVERAGE	BENEFIT AMOUNT	
	In-Network Provider	**Out-of-Network Provider**
Surgeon (In or Outpatient) Benefits	90% of the Preferred Allowance	70% of URC
Assistant Surgeon Benefit	90% of the Preferred Allowance	70% of URC
Pre-Admission Testing Benefit	90% of the Preferred Allowance	70% of URC
Anesthesia Benefit	90% of the Preferred Allowance	70% of URC
Day Surgery Miscellaneous Benefit	90% of the Preferred Allowance	70% of URC
Diagnostic X-Ray and Lab Benefit	90% of the Preferred Allowance *(Cat Scan, PET Scan or MRI subject to a $200 copay)*	70% of URC *(Cat Scan, PET Scan or MRI subject to a $200 deductible)*
Ambulance Benefit	90% of the Preferred Allowance	70% of Actual Charges
Physician Visit Benefit (Inpatient)	90% of the Preferred Allowance	70% of URC
Physician Visit Benefit (Outpatient)	90% of the Preferred Allowance, subject to a $25 copay at Primary Care Physician and Specialist *($0 copay at Student Health Center, 100% coinsurance)*	70% of URC, subject to a $25 deductible at Primary Care Physician and Specialist
Consultant Physician Benefit	90% of the Preferred Allowance, subject to a $25 copay	70% of URC, subject to a $25 deductible
Radiation/Chemotherapy Benefit	90% of the Preferred Allowance	70% of URC
Emergency Room Benefit	90% of the Preferred Allowance, subject to a $200 copay *(waived if admitted)*	70% of URC, subject to a $200 deductible *(waived if admitted)*

BENEFIT COVERAGE	BENEFIT AMOUNT	
	In-Network Provider	**Out-of-Network Provider**
Wellness Medical Benefit	90% of the Preferred Allowance, up to a maximum of $500	No Benefit
Maternity and Pre-Natal Care Expense Benefit	Covered as any other Sickness	Covered as any other Sickness
MENTAL & NERVOUS CONDITIONS EXPENSE BENEFIT AND ALCOHOL & DRUG ABUSE EXPENSE BENEFIT		
In-Patient Expense	90% of the Preferred Allowance	70% of URC
Out-Patient Expense	90% of the Preferred Allowance	70% of URC
Therapeutic Termination of Pregnancy Benefit	90% of the Preferred Allowance, up to $500 maximum benefit	70% of URC, up to $500 maximum benefit
Emergency Dental Expense Benefit	90% of the Preferred Allowance, up to $1,000 maximum benefit, $250 per tooth	90% of URC, up to $1,000 maximum benefit, $250 per tooth
Physiotherapy Expense Benefit - Inpatient	90% of the Preferred Allowance	70% of URC
Physiotherapy Expense Benefit - Outpatient	90% of the Preferred Allowance	70% of URC
Durable Medical Equipment Expense Benefit	90% of the Preferred Allowance	70% of URC
Emergency Medical Evacuation Expense Benefit	100% of actual expense, up to $250,000	
Return of Mortal Remains Expense Benefit	100% of actual expense, up to $100,000	
Family Assistance Benefit	100% of actual expenses, up to $2,500 maximum for room & board and round trip economy air fare	

BENEFIT COVERAGE	BENEFIT AMOUNT	
	In-Network Provider	**Out-of-Network Provider**
PRESCRIPTION DRUG EXPENSE BENEFIT		
Covered Percentage:	100% of the Preferred Allowance, after a $25 deductible per prescription	

NOTES:

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

DEFINITIONS

The male pronoun includes the female whenever used.

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.

Accident means an unforeseeable event which:

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

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

Benefit Period means the period of time from the date of the Accident causing the Injury 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.

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 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.

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 Crum & Forster SPC on and behalf of ITI SP. Also hereinafter referred to as We, Us and Our.

Complications of Pregnancy means a condition which:

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

  Complications of Pregnancy will not include:

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

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

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

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

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

Covered Loss or Covered Losses means an accidental death, dismemberment, Sickness or other Injury covered under the Policy 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 Policy. 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, Domestic Partner, or Civil Union Partner.
2) unmarried Children under age 26.

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

Domestic Partner means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Plan Participant and shared financial assets/obligations with the Plan Participant. Both the Plan Participant and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Plan Participant nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

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

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:

- 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.

Expatriate means (1) a person working or living outside their country of citizenship; (2) a person working outside their country of citizenship and outside the employer's country of domicile; or (3) non-U.S. citizens working in the United States.

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, policy 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, holds a current and valid passport, and to which he or she has the intention of returning.

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 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.

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.

Immunizations Include:, flu shot, tetanus, diphtheria, pertussis, Tdap, hepatitis A, hepatitis B, HPV, measles-mumps-rubella, pneumonia, varicella, meningococcal; only as recommended by the U.S. Centers for Disease Control and Prevention.

Injury means bodily harm which results independently of disease or bodily infirmity, from an Accident. All injuries to the same Plan Participant sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

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

Insurance means the coverage that is provided under the Policy.

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 Policy.

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.

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

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

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

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

Permanent Residence means the country where a Plan Participant has his or her true, fixed and permanent home and principal establishment, 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 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 holds a current and valid passport.

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.

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 Policy. 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, Domestic Partner, or Civil Partner.

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

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

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

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

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 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 Crum & Forster 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.

ELIGIBILITY FOR INSURANCE

Persons eligible to be a Plan Participant under the Policy are those persons described as an ELIGIBLE CLASS on the Schedule of Benefits. 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

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.

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.

EFFECTIVE DATES OF INSURANCE

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 cancelled 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; or
2) The date the Company receives a completed application or enrollment form; or
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; or
4) The moment the Plan Participant exits their Home Country airspace**;** or
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.

TERMINATION DATE OF INSURANCE

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.

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 it's 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 Policy;
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, provided the Company has given the Participating Organization at least 30 calendar days prior written notice; and
6) 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 Policy, 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:

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

1) The date the Plan Participant is no longer in an Eligible Class; or
2) The date the Plan Participant returns to his or her Home Country; or;
3) The expiration of 364 days from the Effective Date of Coverage; or
4) The date shown on the Evidence of Coverage issued by the Company; or
5) The date the Plan Participant becomes a permanent resident of the United States; or
6) The date that 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; or
8) The date the Policy is terminated; or
9) The date the Plan Participant requests, in writing, that his/her coverage be terminated; or
10) The date the Plan Participant's participation in the Program terminates; or
11) The date the Plan Participant's Trip is completed; or
12) The date the Participating Organization is no longer eligible to sponsor coverage under the Policy; or
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.

Dependent's Termination Date

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

1) The date the Policy 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; or

5) The end of the Benefit Period shown in the Schedule of Benefits.

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 Policy. Premium payment made in advance or for more than a one month period will not affect any provisions of the Policy with regard to change. Premiums due for the Policy 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. Premium is due at the time of enrollment.

Failure by the Policyholder 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.

The Company has the right to rely upon the accuracy of the Participating Organization's calculations and to require the Participating Organization to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Participating Organization will pay the additional premium or apply the premium credit at the next premium due date.

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 Policy. 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 Policy 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 Policy.

2) A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy.

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 Policy

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 Policy 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 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.

Terms of Payment for Benefits:

Full Excess Medical Expense

If an Injury or Sickness to the Plan Participant results in his incurring Eligible Expenses for any of the services in the SCHEDULE OF BENEFITS, We will pay the Eligible Expenses incurred, subject to any applicable Deductible Amount, 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.

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 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 Benefit.

Benefits are payable if such Injury:

1) 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 other than as expressly described above, unless previously consented to in writing by the Company.

Loss of:	**Benefit: Principal Sum**
Loss of Life	$5,000
Loss of Both Hands	$5,000
Loss of Both Feet	$5,000
Loss of Entire Sight of Both Eyes	$5,000
Loss of One Hand and One Foot	$5,000
Loss of One Hand and Entire Sight of One Eye	$5,000
Loss of One Foot and Entire Sight of One Eye	$5,000
Loss of One Hand	$2,500
Loss of One Foot	$2,500
Loss of Entire Sight of One Eye	$2,500
Loss of Thumb and Index Finger of the Same Hand	$1,250

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 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.

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 30 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) 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.

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.

ASSISTANT SURGEON BENEFIT

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

PRE-ADMISSION TESTING BENEFIT

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

ANESTHESIA BENEFIT

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

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

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 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.

EXTENSION OF ACCIDENT AND SICKNESS MEDICAL BENEFITS

If a Plan Participant is under the care and treatment of a Physician and Hospital confined on the Termination Date of the Policy benefits will continue to be paid for that condition for a period of up to 90 days, or the maximum benefit has been paid, whichever occurs first.

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;
    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.)

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 NERVIOUS 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;

e) specific obsessive-compulsive disorder;

f) delusional disorders;

g) obsessive compulsive disorders;

h) 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:

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

c) motivating the individual to participate in the appropriate addictions treatment programs for Alcohol and Drug Abuse.

ELECTIVE/THERAPEUTIC 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. 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 c**harges 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, massage or any form of physical therapy.

DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

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

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

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

1) is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;

2) can withstand long-term repeated use without replacement;

3) is not useful in the absence of an Injury or Sickness; and

4) can be used in the home without medical supervision.

EMERGENCY MEDICAL EVACUATION AND RETURN OF REMAINS

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

1) Emergency Medical Evacuation: If the local attending Legally Qualified Physician and the authorized travel assistance company determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment.
2) Return of Remains: In the event of Your death during a Trip, the expense incurred within 30 days from the date of the Covered Loss will be paid for minimally necessary casket or air tray, preparation and transportation of Your remains to Your primary place of residence or to the place of burial.

FAMILY ASSISTANCE BENEFIT

If the Primary Insured requires hospitalization exceeding seven (3) days we will pay the round trip air-fare based on the most economical air fare, and for room and board expenses, up to $2,500, for a family member to provide assistance. All expenses must be approved by the assistances company.

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses, subject to the Copayment, Deductible 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.

EXCLUSIONS

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

1) War or any act of war, declared or undeclared;
2) 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;
3) Voluntary, active participation in a riot or insurrection;
4) 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;
5) Charges provided at no cost to the Plan Participant;
6) Expenses incurred for treatment while in Your Home Country;
7) Regular health checkups; routine physical, immunizations or other examination; unless specifically covered by this Policy;
8) 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;
9) Drug, treatment or procedure that either promotes or prevents conception, or prevents childbirth, including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal thereof;
10) Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes;

11) Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Plan Participant is covered under the Policy, and rendered within 6 months of the Accident;

12) Eyeglasses, contact lenses, hearing aids, or examinations or prescriptions therefore;

13) Practice or play in any interscholastic, intercollegiate, professional or semiprofessional sports contest or competition;

14) Rest cures or custodial care;

15) Weight reduction programs or surgical treatment of obesity;

16) 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);

17) 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;

18) Plan Participant being exposed to the Utilization of nuclear, chemical or biological weapons of mass destruction;

19) Treatment of HIV infection, HIV related illness and AIDS (acquired immune deficiency syndrome in excess of a lifetime maximum of $7,500.

CLAIM PROVISIONS

NOTICE OF CLAIM:

Written notice of death, or Injury or Sickness must be given to Us within 30 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 30 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 30 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 Policy provides periodic payment contingent upon continuing loss within 60 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 60 days after the date of such loss.

If the proof of loss is not submitted 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, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIMELY FILING OF CLAIMS:

All claims for benefits under the Policy must be submitted to Us no more than 90 days from the date of service or date of death.

TIME OF PAYMENT OF CLAIMS:

Benefits due under the Policy for a loss, other than a loss for which the Policy 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 Policy 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 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.

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 Policy on file with the Policyholder, if any, otherwise;
2) Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, 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, 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 Policyholder. When a request for designation or change is received by the Policyholder, 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 Policyholder. 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 Policy 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 Policy 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

In the event that you remain dissatisfied and wish to make a complaint you can do so to the Complaints team at:

Gallagher Student Health & Special Risk, 500 Victory Road, Quincy, MA 02171.
Phone: 617-770-9889
Toll Free: 800-457-5599
Fax: 617-479-0860

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.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:

The Policy, the application of the Policyholder, 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 Policyholder, 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 Policy will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE:

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

RECORDS MAINTAINED:

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

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

(1) The two year period after the expiration of the Policyholder's coverage; or

(2) The final adjustment and settlement of all claims under the Policyholder's coverage.

REPORTING REQUIREMENTS:

The Policyholder 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 Policy;

(2) The names of all persons who are Plan Participant after the Effective Date of the Policy;

(3) The names of those persons whose insurance has terminated; and

(4) Additional information required as agreed to by Us and the Policyholder.

EVIDENCE OF COVERAGE:

A 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.

POLICY TERMINATION:

We may terminate coverage on or after the anniversary of any premium due date. The Policyholder 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 Policy. 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 Policyholder 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 Policyholder will not impose upon the Company any liability other than

the liability defined in the Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Plan Participants under the Policy.

WAIVER:

Failure of the Company to strictly enforce its rights under the Policy 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.