Medical Schedule Benefits by Plan

	ECONOMY AGE 14 DAYS TO AGE 69	BASIC AGE 14 DAYS TO AGE 69	SILVER AGE 14 DAYS TO AGE 69	GOLD AGE 14 DAYS TO AGE 69	PLATINUM AGE 14 DAYS TO AGE 69	DIAMOND and DIAMOND Plus AGE 70 TO AGE 89
Policy Maximums	**$25,000** Max per Injury/Sickness	**$50,000** Max per Injury/Sickness	**$75,000** Max per Injury/Sickness	**$100,000** Max per Injury/Sickness	**$175,000** Max per Injury/Sickness	Diamond $50,000 Annual Max Diamond Plus $100,000 Annual Max
	Acute Onset of Cardiac Conditions/Treatment $25,000 per Policy Period Limit					Acute Onset of Cardiac Conditions/ Treatment $15,000
Deductible options (per Incidence)	$0					$100 or $200
MEDICAL EXPENSE BENEFIT AND EXPENSES ARE PAYABLE UP TO THE MAXIMUM AMOUNT LISTED						
Inpatient Hospital Expense						
Hospital Room and Board Expenses	$1,400 per day to a maximum of 30 days	$1,400 per day to a maximum of 30 days	$1,750 per day to a maximum of 30 days	$2,000 per day to a maximum of 30 days	$2,700 per day to a maximum of 30 days	$1,500 per day to a maximum of 30 days
Hospital Intensive Care Unit Expenses	Additional $700 per day to a maximum of 10 days	Additional $700 per day to a maximum of 10 days	Additional $800 per day to a maximum of 10 days	Additional $900 per day to a maximum of 10 days	Additional $1,150 per day to a maximum of 10 days	Additional $800 per day to a maximum of 10 days
Inpatient Ancillary Hospital Services	Included under the Hospital Room and Board Expenses					
Physician's Surgical Treatment	$3,500 per Incident	$3,500 per Incident	$4,750 per Incident	$6,000 per Incident	$7,500 per Incident	$3,500 per Incident
Anesthesiologist Expense	$850 per Incident	$850 per Incident	$1,200 per Incident	$1,400 per Incident	$1,800 per Incident	$850 per Incident
Assistant Physician's Surgical Expenses	$850 per Incident	$850 per Incident	$1,200 per Incident	$1,400 per Incident	$1,800 per Incident	$850 per Incident
Physician's Non-Surgical Visits	Limited to $55 per visit, one visit per day and 30 visits per Policy Period	Limited to $55 per visit, one visit per day and 30 visits per Policy Period	Limited to $70 per visit, one visit per day and 30 visits per Policy Period	Limited to $85 per visit, one visit per day and 30 visits per Policy Period	Limited to $115 per visit, one visit per day and 30 visits per Policy Period	Limited to $55 per visit, one visit per day and 30 visits per Policy Period
Consulting Physician	$450 per Incident	$450 per Incident	$550 per Incident	$550 per Incident	$700 per Incident	$450 per Incident
Private Duty Nurse	$450 per Incident	$450 per Incident	$550 per Incident	$550 per Incident	$700 per Incident	$450 per Incident
Pre-Admission Test within 7 days of Admission	$1,100 per Incident	$1,100 per Incident	$1,100 per Incident	$1,200 per Incident	$1,500 per Incident	$1,100 per Incident

OUTPATIENT - Maximum Daily Benefit All Services $10,000 – up to the selected policy maximum						
Physician's Surgical Treatment	$3,500 per Incident	$3,500 per Incident	$4,750 per Incident	$6,000 per Incident	$7,500 per Incident	$3,500 per Incident
Anesthesiologist Expense	$850 per Incident	$850 per Incident	$1,200 per Incident	$1,400 per Incident	$1,800 per Incident	$700 per Incident
Assistant Physician's Surgical Expenses	$850 per Incident	$850 per Incident	$1,200 per Incident	$1,400 per Incident	$1,800 per Incident	$700 per Incident
Physician's Visits/ Urgent Care or **Telemedicine	Limited to $55 per visit, one visit per day and 30 visits per Policy Period	Limited to $55 per visit, one visit per day and 30 visits per Policy Period	Limited to $70 per visit, one visit per day and 30 visits per Policy Period	Limited to $85 per visit, one visit per day and 30 visits per Policy Period	Limited to $115 per visit, one visit per day and 30 visits per Policy Period	Limited to $55 per visit, one visit per day and 30 visits per Policy Period
Diagnostic X-rays and Lab Services	$450 per Incident	$450 per Incident	$475 per Incident	$500 per Incident	$675 per Incident	$450 per Incident
Scans, Pet Scan or MRI	$650 per Incident	$650 per Incident	$875 per Incident	$1,050 per Incident	$1,300 per Incident	$650 per Incident
Emergency Room Illness with no direct Hospital Admission	$350 and an additional $200 Deductible per visit - Only applies when receiving care in an Emergency room for an Illness that does not result in a hospital admittance.	$350 and an additional $200 Deductible per visit - Only applies when receiving care in an Emergency room for an Illness that does not result in a hospital admittance.	$450 and an additional $200 Deductible per visit - Only applies when receiving care in an Emergency room for an Illness that does not result in a hospital admittance.	$550 and an additional $200 Deductible per visit - Only applies when receiving care in an Emergency room for an Illness that does not result in a hospital admittance.	$800 and an additional $200 Deductible per visit - Only applies when receiving care in an Emergency room for an Illness that does not result in a hospital admittance.	$350 and an additional $200 Deductible per visit - Only applies when receiving care in an Emergency room for an Illness that does not result in a hospital admittance.
Emergency Room injury/Accident or Illness with direct Hospital Admission	$350 per Incident	$350 per Incident	$450 per Incident	$550 per Incident	$800 per Incident	$350 per Incident
Prescription drugs and medications	$100 per Incident	$100 per Incident	$125 per Incident	$150 per Incident	$200 per Incident	$90 per Incident
Outpatient Surgical Facility	$1,000 per Incident	$1,000 per Incident	$1,150 per Incident	$1,275 per Incident	$1,400 per Incident	$1,000 per Incident
ADDITIONAL MEDICAL TREATMENT AND SERVICES						
Acute Onset of a Pre-Existing Condition	For ages up to and including 69 the limit is up to the Medical Policy Maximum purchased per Period of Coverage except for any coverage related to cardiac disease or conditions, which will be limited to $25,000 up to and including age 69 and $15,000 for ages 70 and above. Upon attaining ages 70-79 Acute Onset benefits will be reduced to a Maximum of $35,000, **upon attaining age 80 Acute Onset benefits will be reduced to a Maximum of $15,000** with a $25,000 Maximum Lifetime Limit for Emergency Medical Evacuation. Provides coverage for an Acute Onset of a Pre-Existing Condition. Any repeat/reoccurrence within the same policy period will no longer be considered Acute Onset of a Pre-Existing Condition and will not be eligible for additional coverage. A Pre-Existing Condition which is a chronic or congenital condition or that gradually becomes worse over time and/or known, scheduled, required, or expected medical care, drugs or treatments existing or necessary prior to the Effective Date are not considered to be an Acute Onset. This benefit covers only ONE (1) Acute Onset episode of a Pre-Existing condition. Sudden and Acute Onset of a Pre-Existing Condition Coverage expires upon medical advice that the condition and Onset is no longer acute, or you are discharged from a medical facility.					
Well Doctor Visit	Pays up to $75 - One Visit per person per Policy Period. The Well Doctor Visit must occur within the first 21 days from the effective date of coverage. To be eligible you must purchase at least 30 days of coverage initially.					
Dental Treatment for Injury to sound natural teeth	$600 per Incident	$600 per Incident	$600 per Incident	$600 per Incident	$600 per Incident	$600 per Incident

Mental or Nervous Disorder & Substance Abuse treatment	$5,000 per Incident	$5,000 per Incident	$5,000 per Incident	$5,000 per Incident	$20,000 per Incident /30 days Max	$5,000 per Incident
Physiotherapy Physical Medicine/Chiropractic Expenses	Limited to $40 per visit, one visit per day and 12 visits per Policy Period	Limited to $40 per visit, one visit per day and 12 visits per Policy Period	Limited to $40 per visit, one visit per day and 12 visits per Policy Period	Limited to $40 per visit, one visit per day and 12 visits per Policy Period	Limited to $60 per visit, one visit per day and 12 visits per Policy Period	Limited to $40 per visit, one visit per day and 12 visits per Policy Period
Chemotherapy &/or radiation therapy	$1,100 per Incident	$1,100 per Incident	$1,225 per Incident	$1,350 per Incident	$1,750 per Incident	$1,100 per Incident
Initial Orthopedic Prosthesis/brace	$1,100 per Incident	$1,100 per Incident	$1,225 per Incident	$1,350 per Incident	$1,750 per Incident	$1,100 per Incident
*Return to Home Coverage	Up to 30 days per 12 months Max $2,000	Up to 30 days per 12 months Max $2,000	Up to 60 days per 12 months Max $2,500	Up to 60 days per 12 months Max $2,500	Up to 90 days per 12 months Max $7,500	N/A
TRANSPORTATION EXPENSES						
AMBULANCE SERVICE BENEFITS	$500 per Incident	$500 per Incident	$500 per Incident	$500 per Incident	$750 per Incident	$500 per Incident
*EMERGENCY MEDICAL EVACUATION	$100,000	$100,000	$100,000	Unlimited	Unlimited	$50,000 and $25,000 Lifetime Maximum for Acute Onset over age of 80
*NATURAL DISASTERS, POLITICAL EVACUATION & REPATRIATION	$500	$500	$1,000	$1,500	$2,000	$500
*RETURN OF MINOR CHILDREN OR GRAND-CHILDREN	$5,000	$5,000	$7,500	$7,500	$10,000	$5,000
*REPATRIATION OF MORTAL REMAINS	$7,500	$7,500	$10,000	$20,000	$25,000	$7,500
*LOCAL BURIAL / CREMATION	$5,000 per Incident	$5,000 per Incident	$5,000 per Incident	$5,000 per Incident	$5,000 per Incident	$5,000 per Incident
ADDITONAL BENEFITS						
*COMMON CARRIER ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) - Insured	$25,000 Principal Sum	$25,000 Principal Sum	$35,000 Principal Sum	$35,000 Principal Sum	$35,000 Principal Sum	N/A
*FELONIOUS ASSAULT ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) - Insured	$5,000 per Policy Period	$5,000 per Policy Period	$7,500 per Policy Period	$7,500 per Policy Period	$10,000 per Policy Period	$5,000 per Policy Period
**TRAVEL ASSISTANCE	Included					

*Not Subject to the Deductible

** This is a non-insurance service and is not a part of the insurance underwritten by Crum & Forster, SPC.

GENERAL TERMS OF COVERAGE

ELIGIBILITY

This Policy provides coverage to non-US citizens who reside outside the USA and are traveling outside of Their Home Country to visit solely the United States, or to visit a combination of the United States and other countries worldwide. The Insured must arrive in the USA before traveling to other countries. This Policy is not available to green card holders in the USA. This Policy is not available to anyone age 90 or above. Coverage in countries outside the USA and your Home Country is available for up to 180 days during your Policy Period.

We maintain Our right to investigate to verify that the eligibility requirements have been met. If and whenever We discover that the eligibility requirements have not been met, Our only obligation is refund of premium. Maximum Age: Coverage ceases on the Covered Person's 90th birthday.

CONTINUATION OF TREATMENT PERIOD

If a covered Sickness or Injury requires continuing Treatment after the expiration of the Policy Period, a Covered Person may receive continuing Treatment for the covered Sickness or Injury for up to six (6) months per Sickness or Injury, subject to the following: if the Policy Period expires while the Covered Person is outside the Home Country, a covered Sickness or Injury incurred while outside and prior to returning to the Home Country, and that covered Sickness or Injury requires continuing Treatment, the Company will review and determine the date of initial Treatment for the covered Sickness or Injury, and if such date is prior to the expiration of the Policy Period, Eligible Medical Expenses for the covered Sickness or Injury will continue to be reimbursed until there has been at least the minimum number of days of continuous Treatment for the covered Sickness or Injury, subject to the limits set forth in the Schedule of Benefits/Limits, and all other Terms of the insurance plan. In order to be eligible for coverage under the Continuation of Treatment Period provision, the Covered Person must be covered by an insurance policy, benefit plan, or Other Coverage for expenses or charges incurred by the Covered Person, and the Other Coverage remains in effect during the duration of coverage with the Company.

EFFECTIVE DATE

An eligible person will be insured on the latest of the following dates: 1. the Covered Person’s departure from Their Home Country; 2. the date and time the Covered Person completed enrollment form and Their correct premium is received; or 3. the effective date requested and shown on the certificate.

TERMINATION DATE

The coverage provided with respect to the Named Insured shall terminate at 12:01 AM North American Central Time on the earliest of the following dates: 1. The date shown on the insurance confirmation card, for which the premium is paid; or 2. The date the Covered Person returns to Their Home Country, except as provided under Return to Home Country Benefit, if eligible; or 3. Three hundred and sixty-four (364) days after the Covered Person's original effective date, unless extended; or 4. The date the Covered Person becomes a United States citizen.

EXTENSION PROCEDURES

An extension notice will be sent to the Covered Person before the Policy Period ends and includes links to extend prior to the termination date. The Covered Person is subject to the following rules at extension: If it is initially purchased for a minimum of 5 days. If available, additional periods are charged at the

premium rate in force at the time of extension. 5 days premium is the minimum acceptable extension premium and 364 days premium is the maximum. There are no grace periods for extension. Once the policy has lapsed, reapplication is required. Please note, upon application for a new policy, the Pre-Existing Condition exclusion, deductible and co-insurance start over.

CANCELLATION AND REFUND PROCEDURE PROVISIONS

Full cancellation and refund will only be considered if We receive written request prior to the Effective Date of the coverage. If We receive a written request for cancellation and refund after the Effective Date of coverage, a partial cancellation and refund may be allowed. The following conditions apply: a) If any claims have been filed with Us, the premium is fully earned and is non-refundable. b) If no claims have been filed with the Company, then (i) a cancellation fee of US $25 will be charged; and (ii) only unused days premiums will be considered as refundable; and c) If after a refund is made, it is determined that a claim was presented to Us on a Covered Person's behalf, the Covered Person will be fully responsible for that claim in its entirety.

DISCLOSURES

Client must notify the Plan Administrator within 30 days of a change of address or domicile.

POLICY TERMS AND CONDITIONS

All benefits payable are subject to the Maximum Benefit Limits, and any applicable sub-limits, listed in the Schedule of Benefits.

MEDICAL EXPENSE BENEFIT

If a covered Sickness or Injury occurs during the Policy Period, and the Covered Person requires medical or surgical treatment, benefits are payable for the following covered expenses:

INPATIENT HOSPITAL BENEFITS:

Inpatient means a person was admitted to an approved Hospital or other health care facility for a Medically Necessary overnight stay. Inpatient Hospitalization services as specified in the Schedule of Benefits include, but are not limited to:

- Hospital Room and Board Expenses: the average daily rate for a semi-private room when a Covered Person is Hospital Confined (In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge), and general nursing care and the following additional facilities; services and supplies as Medically Necessary and approved and covered by the Policy, meals and special diets (only for the patient). Use of operating room and related facilities, use of intensive care and related services. All charges in excess of the allowable semiprivate rate are the responsibility of the Covered Person.

- Hospital Intensive Care Unit services will be provided based on the Allowable Charge for Medically Necessary Intensive Care Services.

- Inpatient Ancillary Hospital Services - If medically necessary for the diagnosis and treatment of the Sickness or Injury for which a Covered Person is hospitalized, the following services are also covered: use of operation room and recovery room; all medicines listed in the U.S. Pharmacopoeia or National

Formulary; Blood transfusions, blood plasma, blood plasma expanders, and all related testing, components, equipment and services; Surgical dressings; Laboratory testing; Durable Medical Equipment; Diagnostic x-ray examinations; Radiation therapy rendered by a radiologist for proven malignancy or neoplastic diseases; Respiratory therapy rendered by a Physician or registered respiratory therapist; chemotherapy rendered by a Physician or Nurse under the direction of a Physician; Physical and Occupational therapy (if covered) must be rendered by a Physician or registered physical or occupational therapist and relate specifically to the physician's written treatment plan. Therapy must: Produce significant improvement in the Insured's condition in a reasonable and predictable period of time, and be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed only by a registered physical or occupational therapist, or be necessary to the establishment of an effective maintenance program. Maintenance itself is not covered. All Inpatient Ancillary benefits are paid in accordance with the current Schedule of Benefits.

- Physician's Surgical Treatment
- Anesthetist: Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure on an inpatient basis.
- Assistant Physician's Surgeon (When Medically Necessary)
- Physician's Non-Surgical Visits: Physician non-surgical treatment and examination expenses including the Physician's initial visit, each Medically Necessary follow-up visit and consultation visits when referred by the attending Physician.
- Consulting Physician, when requested by attending Physician
- Private Duty Nurse
- Pre-Admission Test within 7 days of Admission

OUTPATIENT HOSPITAL BENEFITS:
Outpatient means a person is admitted to a Hospital or other healthcare facility for treatment that does not require an overnight stay. Outpatient Hospitalization services as specified in the Schedule of Benefits include, but are not limited to:

- Physician's Surgical Treatment
- Diagnostic X-Rays and Lab Services: to include X-ray, laboratory and other diagnostic tests, biological anesthesia and oxygen services, radiation therapy, inhalation therapy, chemotherapy and administration of blood products
- Prescription drugs and medications

- Scans, PET scan or MRI
- Anesthetist: Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure on an inpatient basis
- Physician's Visits/Urgent Care
- **Telemedicine (please see link for Telemedicine Benefit)
- Hospital Emergency Room Visits. Emergency Room Visit for an Illness with no direct Hospital Admittance will be subject to an additional deductible as outlined in the schedule of benefits.

ADDITIONAL MEDICAL TREATMENT AND SERVICES

- Acute Onset of a Pre-existing Condition (Per Policy Period) Benefits are payable for an Acute Onset of a Pre-Existing Condition. Any repeat/reoccurrence within the same Policy Period will no longer be considered Acute Onset of a Pre-Existing Condition and will not be eligible for additional coverage. A Pre-Existing Condition which is a chronic or congenital condition or that gradually becomes worse over time and/or known, scheduled, required, or expected medical care, drugs or treatments existing or necessary prior to the Effective Date are not considered to be an Acute Onset. This benefit covers only one (1) Acute Onset episode of a Pre-Existing condition. Sudden and Acute Onset of a Pre-Existing Condition Coverage expires upon medical advice that the condition and onset is no longer acute, or the Covered Person is discharged from a medical facility.

- Well Doctor Visit - Benefits will be payable for a Well Doctor Visit per person during the Policy Period. The Covered Person may use any Physician. Telemedicine is not eligible. To be covered: 1. the visit must occur within the first 21 days from the effective date of coverage and 2. the Covered Person must purchase at least 30 days of coverage initially; and the Physician must use specific ICD10 codes for the Well Visit which are the following three Diagnosis Codes only a) V70.0-Routine medical exam; b) Z00.00-Encounter for general adult medical examination without abnormal findings c) Z00.129-Encounter for routine child health examination without abnormal findings. Visits with ICD10 Codes not listed here are not considered Well Doctor Visits and are not covered as such but may be covered under another policy benefit. Please register for this benefit with the Plan Administrator. https://TrawickInternational.com/wellness/Register
- Emergency dental treatment and restoration of sound natural teeth, including x-rays, required as a result of an Accident. Routine dental treatment is not covered.
- Initial Orthopedic Prosthesis/brace: Prosthesis and corrective devices such as Durable Medical Equipment which are medically required as an integral part of treatment prescribed by a physician; Prosthesis/ Durable Medical Equipment does not include: motor driven wheelchairs or bed; comfort items such as telephone arms and over bed tables; items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and

purifiers (air cleaners); disposable supplies; exercise cycles, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment, and similar items.

- Mental or nervous disorders or treatment. Benefits are provided for psychotherapeutic treatment and psychiatric counseling and treatment for an approved psychiatric diagnosis. Benefits are for both inpatient mental health treatment in Hospital, or approved facility and for outpatient mental health treatment will be applied toward the Policy Period per person Maximum. A Physician or a licensed clinical psychologist must provide all mental health care services. Services of a clinical psychologist must be rendered in the provider's office or in the outpatient department of a Hospital. Services Include treatment for Bulimia; Anorexia; Non-medical causes of insomnia; Outpatient & Inpatient rehabilitation all treatment programs must be Pre-authorized. The following services are excluded: Aptitude testing, educational testing and services; Services for conditions not determined by Us as to be emotional or personality Sicknesses; Psychiatric services extending beyond the period necessary for evaluation and Diagnosis of mental deficiency or retardation; Services for mental disorders or Sickness which are not amenable to favorable modification; Bereavement; Family counseling of any kind; Marriage counseling of any kind.

- Physiotherapy Physical Medicine/Chiropractic Expenses on an Inpatient or outpatient basis including treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, adjustments, manipulation, or any form of physical therapy.

TRANSPORTATION BENEFITS

AMBULANCE SERVICE BENEFITS

Ambulance Service Benefits are provided for medically necessary emergency ground ambulance transportation as required from the emergency site to the nearest Hospital able to provide the required level of care.

EMERGENCY MEDICAL EVACUATION

Benefits are payable for the cost of emergency evacuation when deemed necessary and pre-approved by the Assistance Provider to a suitable location to render immediate and appropriate care. The Assistance Provider will determine the destination country of the evacuation, and the country may or may not be the Home Country of origin. If the Insured does not obtain pre-approval from the Assistance Provider, We reserve the right to deny coverage or assess a 20 % co-payment for the associated costs. Upon attaining age 80 Acute Onset benefits will be reduced to a $25,000 Maximum Lifetime Limit for Emergency Medical Evacuation.

MEDICAL REPATRIATION TO HOME COUNTRY

Repatriation for Medical Treatment: The Assistance Provider reserves the right to review any case in which the Covered Person is medically stable and upon advice of the Assistance Provider’s medical doctors can be evacuated at the Assistance Provider's discretion to the Covered Person’s Home Country.

NATURAL DISASTERS, POLITICAL EVACUATION & REPATRIATION

Provides a benefit for evacuation during a period of civil unrest, insurrection or Natural Disaster that could not have been foreseen prior to departure from the Home Country of origin. Coverage is NOT valid in any country that was on verge, already in or under duress for a period of 60 days prior to departure from point of origin or country of residence. The coverage amount is in the Schedule of Benefits.

REPATRIATION OF MORTAL REMAINS

Benefits are payable for preparation and return of a Covered Person's body to their Home Country if they die due to a covered Sickness or Injury. Covered Expenses include: Expenses for embalming or cremation; The least costly coffin or receptacle adequate for transporting the remains; Transporting the remains by the most direct and least costly conveyance and route possible and pre-approved by the Assistance Provider. Benefits will not be payable unless We authorize in writing or by an authorized electronic or telephonic means all expenses in advance. This benefit excludes fees for return of personal effects, religious or secular memorial services, clergymen, flowers, music, announcements, guest expenses and similar personal burial preferences.

LOCAL BURIAL / CREMATION

Benefits are payable for preparation, local burial or cremation of the Covered Person's mortal remains at the country of death in accordance with the commonly accepted cultural and religious beliefs practiced by the Covered Person. Coverage is not provided for burial and cremation costs incurred for: religious practitioner, flowers, music, food or beverages. If the Local Cremation or Burial is chosen, the Return of Mortal Remains benefit will not apply. Expenses must be approved in advance by the Assistance Provider. Failure to utilize the Assistance Provider to approve these services will result in the denial of benefits.

ADDITIONAL BENEFITS

COMMON CARRIER ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Accidental Death and Dismemberment will apply to Covered Accidents incurred while a Covered Person is traveling/riding as a passenger in or on any public land, water or air conveyance (regularly scheduled and licensed) for transportation of passengers for hire. If Injury to the Covered Person results in any one of the losses shown below within 365 days from date of the Covered Accident, We will pay the Benefit Amount shown below for that loss. If multiple losses occur, only one Benefit Amount, the largest, will be paid for all losses due to the same Covered Accident.

COVERED LOSS	BENEFIT AMOUNT
Loss of Life	100% of Principal Sum
Loss of Speech and Loss of Hearing	100% of Principal Sum
Loss of Speech and one of Loss of Hand, Loss of Foot or Loss of Sight of One Eye	100% of Principal Sum
Loss of Hearing and one of Loss of Hand, Loss of Foot or Loss of Sight of One Eye	100% of Principal Sum
Loss of Hands (Both), Loss of Feet (Both), Loss of Sight or a combination of any two of Loss of Hand, Loss of Foot or Loss of Sight of One Eye	100% of Principal Sum
Quadriplegia	100% of Principal Sum
Paraplegia	75% of Principal Sum

Hemiplegia	50% of Principal Sum
Loss of Hand, Loss of Foot or Loss of Sight of One Eye (any one of each)	50% of Principal Sum
Uniplegia	25% of Principal Sum
Loss of Thumb and Index Finger of the same hand	25% of Principal Sum

FELONIOUS ASSAULT

We will pay the Benefit Amount for Felonious Assault shown in the Schedule of Benefits, if accidental bodily Injury resulting from Felonious Assault causes a Primary Covered Person to suffer Covered Loss. The Benefit Amount for Felonious Assault is payable in addition to any other applicable Benefit Amounts under this policy. Any assault by a family member is not covered under this benefit.

RETURN TO HOME COVERAGE

You may return to your Home Country of residence for up to 90 days during the Policy Period. The benefits available are those as outlined in the Schedule of Benefits and may ONLY be utilized after initially leaving the Home Country of residence and then returning for an incidental trip. The benefits are subject to any policy limitations and all of the exclusions. Not available on the Diamond or Diamond Plus plans.

EXCLUSIONS

Unless specified in the Schedule of Benefits, in any written endorsement, or agreed by the Company in writing, no claim can be made for compensation or payment for damage or expenses caused by or as a result of the following:

1. Pre-Existing Conditions as defined.
2. Costs related to medical examination, treatment and surgical intervention which are not administered in a licensed healthcare institution.
3. Costs related to medical examination where no Sickness has been diagnosed or Accident has been ascertained; for non-specified pain; or preventative or routine exams, except as specifically provided for in this policy.
4. Any visit to a medical provider that does not result in a covered Diagnosis code after medical review or testing.
5. Any treatment by a family member/family associate or any type of direct relationship.
6. In respect of accidental damage to Natural Teeth, no benefit is payable for Injury caused by eating or drinking (even if it contains a foreign body), normal wear and tear, tooth brushing or any other oral hygiene procedure or any means other than extra-oral impact, any form of restorative or remedial work, the use of precious metals, orthodontic treatment of any kind or dental treatment performed in a hospital unless dental surgery is the only treatment available.
7. Suicide or attempted suicide, intentional self-injury, the effect of intoxicating liquors or drugs.
8. Treatment of hernia; Osgood-Schlatters Disease; osteochondritis; osteomyelitis; congenital weakness whether or not caused by a Covered Accident.
9. Evacuation costs where the Insured Person is not being admitted to a Hospital for Treatment or where costs have not been approved by Company prior to travel commencing.
10. Any costs arising after expiry of the current Policy Period unless this plan has been extended for a subsequent 12 months or the Insured Person was being treated during the Policy Period as a result of an accident.
11. Any form of treatment or surgery which in the opinion of the Doctors(s) in attendance and the Assistance Provider that can be delayed until your return to your home country.

12. Medical Expenses incurred after you have returned to your home country which exceed the number of days or in excess of a limit stated in the Schedule of Benefits.
13. Medical Expenses in excess of a limit stated in the Schedule of Benefits.
14. The amount of the Policy Excess, Deductible or Co-Payment, as stated in the Schedule of Benefits.
15. Any cost resulting in a Sickness, Injury or death from the misuse of drugs or being under the influence or effect of alcohol (other than a legally prescribed medication by a licensed medical professional).
16. Needless self-exposure to peril except in an attempt to save human life.
17. Intentional or fraudulent acts on the Insured Person's part or their consequences.
18. Trips specifically made for the purpose of obtaining medical treatment.
19. Cosmetic surgery or remedial surgery, removal of fat or other surplus body tissue and any consequences of such treatment, weight loss or weight problems/eating disorders, whether or not for psychological purposes, unless required as a direct result of an Accident which occurs during the Policy Period.
20. Treatment for alcoholism, narcotics, drug and substance abuse/dependency or any addictive condition of any kind and any Injury or Sickness arising from the Insured Person being under the influence of alcohol, drugs or any other intoxicating substance.
21. Pregnancy, childbirth whether normal or complicated, including the transfer of a pregnant woman to hospital to give routine childbirth or air travel when the Insured Person is more than 20 weeks pregnant and was NOT a result of an accident or onset of complications relating from an accident.
22. Any sexually transmitted or venereal disease; and/or any testing for the following: HIV, Vaccine induced seropositivity to the AIDS virus, AIDS related Illnesses, ARC Syndrome, AIDS.
23. Treatment for transitional life Events, homesickness, fatigue, jetlag or work related stress.
24. Any loss as the result of the use of any type of firearm(s) (Defined as any device that discharges a projectile of any type).
25. Any expenses relating to *search and rescue* operations to find an Insured Person in mountains, at sea, in the desert, in the jungle and similar remote locations, including air/sea rescue charges for evacuation to shore from a vessel or from the sea.
26. Charges or fees incurred for the completion of Medical Claim Forms.
27. Any expenses as the result of or related to participating in any sports or sport related activity. Inclusive of conditions that arise out of sport activity including but not limited to Cardiac, Respiratory, Orthopedic conditions etc.
28. Any loss as the result of the use of a Motorcycle or two or three wheeled device of any kind.
29. The radioactive, toxic, explosive or other hazardous or contaminating properties of any nuclear installation, reactor or other nuclear assembly or nuclear component thereof.
30. War Insurrection and Terrorism related to the following: Nuclear, and Weapons of mass destruction: means the use of any explosive nuclear weapon or device or the emission, discharge, dispersal, release or escape of fissile material emitting a level of radioactivity capable of causing incapacitating disablement or death amongst people or animals. Chemical Weapons: mass destruction means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing incapacitating disablement or death amongst people or animals. Utilization of Biological weapons of mass destruction means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which are capable of causing incapacitating disablement or death amongst people or animals. Terrorism**:** Terrorist activity means

an act, or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist activity can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of terrorist activity can either be acting alone, or on behalf of, or in connection with any organization(s) or governments(s).

31. Any infection of the urinary tract (including, without limitation, infection of the kidney, ureter, bladder, prostate or urethra) and any complication, medical condition or other Illness directly or indirectly arising therefrom, that occurs within ninety (90) days of the Effective Date of this Insurance and that requires Treatment of the Insured Person in a Hospital as an inpatient.
32. Payment for any medical services related to an illness when an Insured Person leaves a medical facility against medical advice.
33. This policy does not cover any type of sports Injury or Sickness.
34. The Covered Person did not exercise reasonable care to prevent accident, Injury, loss or damage and at all times, act as if uninsured.

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The following important definitions apply to this Plan. Please see the Policy for a complete list of definitions.

“Accident” means a sudden, unexpected and unintended event.

“Acute Onset of a Pre-Existing Condition” means a sudden and unexpected outbreak or recurrence of a Pre- Existing Condition which 1) occurs spontaneously and without advance warning either in the form of Physician recommendations or symptoms, is of short duration, is rapidly progressive, and requires urgent and immediate medical care; and 2) occurs a minimum of 48 hours after the Effective Date of the policy and 3) treatment is obtained within 24 hours of the sudden and unexpected outbreak or recurrence. A Pre-Existing Condition that is a Congenital condition or that gradually becomes worse over time will not be considered Acute Onset.

“Assistance Provider” means On Call International.

"Automobile" means a self-propelled, private passenger motor vehicle with four or more wheels that is a type both designed and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, sport utility vehicle, or a motor vehicle of the pickup, van, camper, or motor-home type. Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

“Common Carrier" means any public conveyance that is operated via a published schedule and to which a fare is paid. This is inclusive of Bus, Rail, Air and Sea transportation.

“Company” means Crum & Forster SPC.

“Covered Accident” means an Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Policy for which benefits are payable.

“Covered Expenses” means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies covered by the Policy. Coverage under the Policy must remain continuously in force from the date of the Accident or Sickness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

“Covered Loss” or “Covered Losses” means an accidental death, dismemberment or other Injury covered under the Policy.

“Covered Person” means any Insured and Dependent for whom the required premium is paid (herein also referred to as “ You” or “Your” or “They” or “Their”).

"Deductible" means the dollar amount of Covered Expenses that must be incurred as an out of-pocket expense by each Covered Person on a per incidence basis. The deductible must be met, by the Covered Person before Medical Expense Benefits can be paid or reimbursed. The deductible is applied to the first eligible claim processed.

“Dependent” means an Insured’s lawful spouse or domestic partner; or an Insured’s unmarried child, from the moment of birth to age 21, who is chiefly dependent on the Insured for support. A child, for eligibility purposes, includes an Insured’s natural child; adopted child, beginning with any waiting period pending finalization of the child’s adoption; or a stepchild who resides with the Insured or depends chiefly on the Insured for financial support. A Dependent may also include any person related to the Insured by blood or marriage and for whom the Insured is allowed a deduction under the Internal Revenue Code. Insurance will continue for any Dependent child who reaches the age limit and continues to meet the following conditions: 1. the child is handicapped, 2. is not capable of self-support and 3. depends chiefly on the Insured for support and maintenance. The Insured must send Us satisfactory proof that the child meets these conditions, when requested. We will not ask for proof more than once a year.

"Diagnosis" means the result of examination or test by a licensed physician providing a specific international CPT or ICD10 code. Failure to obtain a covered Diagnosis will result in the denial of the claim.

"Effective Date" means the program shall become effective at 12:01 AM North American Central Time on the latest of the following dates: 1. The Insured Person’s Departure from their Home Country. 2. The date the application and premium are received by the Administrator; or 3. The date the application and premium are accepted by the Administrator; or 4. The date requested on the application.

"Event" means any one incident in which the Covered Person requires care for acute, sudden and unforeseen Medical and Accidental Emergencies and the direct consequence of the Event. Maximum coverage is limited to amounts specified in the Schedule of Benefits. Multiple Events independent of each other are covered to the Event maximum with no limits on the number of Events.

"Home Country" means a country from which the Insured Person holds a passport. If the Insured Person holds passports from more than one country, his or her Home Country will be that country which the Insured Person has declared to Us in writing as his or her Home Country.

“Hospital” means an institution that: 1. operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2. provides 24-hour nursing service by Registered Nurses on duty or call; 3. has a staff of one or more licensed physicians available at all

times; 4. provides organized facilities for diagnosis, treatment and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5. 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 6. is not a place solely for drug addicts, alcoholics, or the aged or any separate ward of the Hospital.

“Hospital Confined” means an overnight stay as a registered resident bed-patient in a Hospital.

“Host Country” means any country, other than an OFAC excluded country, in which the Covered Person is traveling while covered under the Policy.

“Immediate Family Member” means the spouse, parent, parent-in-law, grandparent, child, grandchild, brother, sister, fiancé, such person being related to the Covered Person.

"Incident" Any situation in which the terms and conditions of the policy are activated for either a Sickness, Accident or Injury.

"Injury" means accidental bodily harm sustained by a Covered Person that results, directly and independently from all other causes, from a Covered Accident. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

“Medical Emergency” means a condition caused by an Injury or Sickness that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

“Medically Necessary” means a treatment, service or supply that is: 1. required to treat an Injury or Sickness; prescribed or ordered by a Physician or furnished by a Hospital; 2. performed in the least costly setting required by the Covered Person’s condition; and 3. consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. Purchasing or renting 1. air conditioners; 2. air purifiers; 3. motorized transportation equipment; 4. escalators or elevators in private homes; 5. eye glass frames or lenses; 6. hearing aids; 7. swimming pools or supplies for them; and 8. 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, at Our discretion, consider the cost of the alternative to be the Covered Expense.

“Missing Bag Report” means a formal report of loss as filed with the common carrier commonly known as a PIR (Passenger Irregularity Report) or PAWOB (Passenger Arriving With Out Baggage). This must include the 6-digit Claim Number or the World Tracer Record Number as provided by the carrier.

“Missing Person” means a Covered Person who disappeared for an unknown reason and whose disappearance was reported to the appropriate authority(ies).

“Natural Disaster” means storm (wind, rain, snow, sleet, hail, lightning, dust or sand) earthquake, flood, volcanic eruption, wildfire or other similar event that: 1. is due to natural causes; and 2. results in such severe and widespread damage that the area of damage is officially declared a disaster area by the government in which the Covered Person’s Trip occurs and the area is deemed to be uninhabitable or dangerous.

“Nearest Place of Safety” means a location determined by the Designated Security Consultant where: 1. the Covered Person can be presumed safe from the Occurrence that precipitated the Covered Person’s Political Evacuation; and the Covered Person has access to Transportation; and 2. the Covered Person has the availability of temporary lodging, if needed.

“Necessities” means personal hygiene items and clothing.

“Occurrence” means any of the following situations involving a Covered Person: 1. expulsion from a Host Country or being declared persona non-grata on the written authority of the recognized government of a Host Country; 2. political or military events involving a Host Country, if the Appropriate Authorities issue an Advisory stating that citizens of the Covered Person’s Home Country or citizens of the Host Country should leave the Host Country; 3. deliberate physical harm of the Covered Person confirmed by documentation or physical evidence or a threat against the Covered Person’s health and safety as confirmed by documentation and/or physical evidence; 4. Natural Disaster in the area the Covered Person is traveling to and occurring after Their effective date; 5. the Covered Person had been deemed kidnapped or a Missing Person by local or international authorities and, when found, his or her safety and/or well-being are in question within seven days of his or her being found.

“Physician/Doctor” means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a Covered Person that is appropriate for the conditions and locality. It will not include a Covered Person or a member of the Covered Person’s Immediate Family or household.

“Policy Period” means the dates as shown on the Covered Person’s certificate for which premium has been paid.

“Political Evacuation” means the extrication of a Covered Person from the Host Country due to an Occurrence which could result in grave physical harm or death to the Covered Person and is certified by a governing authority via declaration or warning.

"Pre-certification; Pre-certify" means a general determination of Medical Necessity only, made by the Company in reliance and based upon the completeness and accuracy of the information provided by the Covered Person and/or the Covered Person's healthcare or medical service providers, guardians, Relatives and/or proxies at the time thereof. Pre-certification is not an assurance, authorization, pre-authorization or verification of coverage, a verification of benefits, or a guarantee of payment.

"Pre-Existing Condition” means Any Injury, Illness, Sickness, disease, or other physical, medical, Mental or Nervous Disorder, condition or ailment that, with reasonable medical certainty, existed at the time of Application or at any time during the 36 months prior to the Effective Date of this insurance, whether or not previously manifested, symptomatic or known, diagnosed, Treated, or disclosed to the Company prior to the Effective Date, and including any and all subsequent, chronic or recurring complications or consequences related thereto or resulting or arising therefrom. This specifically includes but is not limited to any medical condition, Sickness, Injury , Illness, disease, Mental Illness or Mental Nervous Disorder, for which medical advice, diagnosis, care or Treatment was recommended or received or for which a reasonably prudent person would have sought Treatment during the 36 month period immediately preceding the Effective Date of Coverage under this Certificate. A Pre-Existing Condition which is a chronic or congenital condition or that gradually becomes worse over time and/or known, scheduled, required, or expected medical care, drugs or Treatments existing or necessary prior to the Effective Date are not considered to be an Acute Onset.

“Related Costs” means food, lodging and, if necessary, physical protection for the Covered Person during the Transport to the Nearest Place of Safety.

“Sickness” means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

“Supplemental Restraint System" means an airbag that inflates upon impact for added protection to the head and chest areas.

"Termination Date" means the coverage provided with respect to the Named Insured shall terminate at 12:01 AM North American Central Time on the earliest of the following dates: 1. The date shown on the insurance confirmation card, for which the premium is paid; or 2. The date the Covered Person returns to Their Home Country, except as provided under Return to Home Country Benefit, if eligible; or 3. Three hundred and sixty-four (364) days after the Covered Person's original effective date, unless extended; or 4. The date the Covered Person becomes a United States citizen.

“Trip” means travel by air, land, or sea from the Covered Person’s Home Country.

“Usual and Customary Charge” means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

“We”, “Our”, “Us” means The Company or Crum & Forster SPC.

“Well Doctor Visit” means one visit to a Physician that occurs within the first 21 days from the effective date and where the provider uses one of these ICD10 Diagnosis codes only - V70.0-Routine medical exam, Z00.00-Encounter for general adult medical examination without abnormal findings c) Z00.129-Encounter for routine child health examination without abnormal findings.

PROVIDER INFORMATION

Preferred Provider Network: The Company maintains a Preferred Provider Network both within and outside the United States. Within the United States, the Company recommends the use of the Preferred Provider Network for maximum benefit payment. Outside the U.S., the Company retains the right to require the use of a Network Provider, where available Or be subject to a 20% copayment on all claims. Utilizing these providers may result in payments directly to the provider as well as referrals to licensed medical providers you can trust. You can find the link to the provider directory at https://www.trawickinternational.com/resources/healthcare-provider-search

In the United States, provider choices and reimbursement assessment will be based as follows:
In-Network Preferred Provider: This tier consists of all In-Network Providers as well as other preferred providers designated by the Company and listed on the website. In-Network Providers have agreed to accept a negotiated discount for services. This results in lower out-of-pocket costs.
Out-Of-Network Provider: Utilizing providers that are Out-of-Network is a more costly financial option for the Insured. The Company reimburses such providers up to a Reasonable and Customary amount as determined by the Company. The provider may bill the Insured the difference between the amounts reimbursed by the Company and the Provider’s billed charge. Additionally, you will pay a Coinsurance amount that is higher than if an In-

Network Provider were used. Amounts in excess of the Reasonable and Customary charges will not count toward the Out-of-Pocket Maximum, Deductibles or Plan Co-payments.

Emergency Care: In an EMERGENCY SITUATION, call for emergency assistance (911 in the United States) and go to the closest emergency facility. If you are not sure where to go you may contact the Assistance Provider at the number on your ID card and they may be able to direct you to the closest network facility. Remember, it is your health so you must act prudently in an emergency and seek the care you need.

Non-Emergency Care: When a non-emergency situation arises in which you need to visit a medical professional please utilize a local doctor, walk-in clinic or urgent care facility. Going to a hospital emergency room for NON-Emergency care will result in additional expenses and out of pocket cost as specified in your Schedule of Benefits. Examples of Non-Emergency care include: sore throat, common cold, minor Injuries and Sicknesses that are not life threatening. NOTE: This policy excludes Injury or Sickness related to sports activity. Please see exclusion section.

Pre-Certification/Notification: Pre-Certification and notification is mandatory. Failure to do so will result in a 50% reduction of the eligible claims Medical Expenses. For Pre-Certification please contact 855-463-8420

Provisions/Requirements

Pre-Certification is a general determination of Medical Necessity, only, and all such determinations are made by the Company (acting through its authorized agents and representatives) in reliance and based upon the completeness and accuracy of the information provided by the Insured Person and/or his/her relatives, guardians and/or healthcare providers at the time of Pre-Certification.

The Company reserves the right to challenge, dispute and/or revoke a prior determination of Medical Necessity based upon subsequent information obtained. Pre-Certification is not an assurance, authorization, pre-authorization, or verification of Treatment or coverage, a verification of benefits, or a guarantee of payment. The fact that Treatment or supplies are Pre-Certified by the Company does not guarantee the payment of benefits, the availability of coverage, or the amount of or eligibility for benefits.

The Company's consideration and determination of a Pre-Certification request, as well as any subsequent review or adjudication of all medical claims submitted in connection therewith, shall remain subject to all of the Terms of the Master Policy and this Certificate, including exclusions for Pre-Existing Conditions and other designated exclusions, benefit limitations and sub-limitations, and the requirement that claims be Usual, Reasonable and Customary.

Also, any consideration or determination of a Pre-Certification request shall not be deemed or considered as the Company's approval, authorization or ratification of, recommendation for, or consent to any diagnosis or proposed course of Treatment. Neither the Company nor the Plan Administrator (nor anyone acting on their respective behalves) has any authority or obligation to select Physicians, Hospitals, or other healthcare providers for the Insured Person, or to make any diagnosis or medical Treatment decisions on behalf of the Insured Person, and all such decisions must be made solely and exclusively by the Insured Person and/or his/her family members or guardians, treating Physicians and other healthcare providers.

If the Insured Person and his/her healthcare providers comply with the Pre-Certification requirements of the Master Policy and this Certificate, and the Treatment or supplies are Pre-Certified as Medically Necessary, the Company will reimburse the Insured Person for Eligible Medical Expenses up to the amount shown in the Schedule of Benefits/Limits incurred in relation thereto, subject to all Terms of this insurance.

Eligibility for and payment of benefits are subject to all of the Terms of this insurance.

Specific Requirements

The following must always be Pre-Certified for Medical Necessity through the Company before admission or receiving the Treatments and/or supplies:

a) Inpatient status.
b) any Surgery or Surgical procedure.
c) any Treatment in an Extended Care Facility.
d) Durable Medical Equipment that exceeds $1,000.
e) artificial limbs.
f) Computerized Axial Tomography (CAT Scan).
g) Magnetic Resonance Imaging (MRI).

Loss of Coverage/Benefits for Non-Compliance with Pre-Certification Requirements

If the Insured Person or his/her healthcare providers do not comply with the foregoing Pre-Certification requirements, all Eligible Medical Expenses incurred with respect to said Treatments and/or supplies will first be reduced by fifty percent (50%), the applicable Deductible will be subtracted from the reduced amount, the Coinsurance will then be applied to the remainder of the reduced amount as applicable, and further benefits, if any under the insurance plan shown in the Declaration, will be available only for the remaining balance of the reduced amount thereafter.

Emergency Pre-Certification - In the event of an Emergency Hospital admission, Pre-Certification must be completed within forty-eight (48) hours after the admission, or as soon as is reasonably possible.

CLAIM PROCEDURES

All claims must be submitted within 90 days of the date of service.

All claims MUST BE ON A FULLY COMPLETED claim form including medical history sections. A claim form must be completed and provided for each medical condition.

Governing Jurisdiction: All claims arising under this insurance shall be governed by the Laws of Cayman Islands whose courts alone shall have jurisdiction in any dispute arising hereunder.

Notice of Claim: A claimant must give Us or Our authorized representative written (or authorized electronic or telephonic) notice of claim within 90 days after any loss covered by the Policy occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify the Covered Person and the Policy Number. All claims must be submitted within 90 days from date of incident or they will be denied. Circumstances may exist in which this is not always possible. Any submissions after 90 days will be considered based on those circumstances.

Claim Forms: Upon receiving written notice of claim, We will provide claim forms to the claimant within 15 days. If We do not furnish such claim forms, the claimant will satisfy the requirements of written proof of loss by sending the written (or authorized electronic or telephonic) proof as shown below. The proof must describe the occurrence, extent and nature of the loss and give authorization to release medical records.

Proof of Loss: Written (or authorized electronic or telephonic) proof of loss must be sent to the agent authorized to receive it. Written (or authorized electronic or telephonic) proof must be given within 90 days after the date of loss. If it cannot be provided within that time, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted if it is sent later than one year from the time proof is otherwise required.

Claimant Cooperation Provision: Failure of a claimant to cooperate with Us in the administration of a claim may result in the delay or termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Time Payment of Claims: Benefits for loss covered by the Policy, other than benefits that require periodic payment, will be paid not more than 60 days after We receive proper written proof of such loss.

Payment of Claims: If the Covered Person dies, any death benefits or other benefits unpaid at the time of the Covered Person's death will be paid to the beneficiary. If no beneficiary is on record with Us or Our authorized agent, payment will be made to the first surviving class of the following to the Covered Person's: 1. spouse; 2. children, in equal shares (If a child is a minor, benefits will be paid to the legal guardian); 3. mother or father; 4. estate. All other benefits due and not assigned will be paid to the Covered Person, if living. Otherwise, the benefits may, at our option, be paid: 1. according to the beneficiary designation; or 2. to the Covered Person's estate. If a benefit due is payable to: 1.the Covered Person's estate; or 2. the Covered Person or a beneficiary who is either a minor or is not competent to give a valid release for the payment, We may pay any amount due to some other person. The other person will be one who we believe is entitled to the payment and who is related to the Covered Person or the beneficiary by blood or marriage. We will be relieved of further responsibility to the extent of any payment made in good faith. We may pay benefits directly to any Hospital or person rendering covered services, unless the Covered Person requests otherwise in writing. The Covered Person must make the request no later than the time he or she files a written proof of loss.

OFAC Compliance: Payment of loss under this policy shall only be made in full compliance with all United States of America economic or trade sanction laws or regulations, including, but not limited to sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").

Beneficiary: The Insured may designate a beneficiary. The Insured has the right to change the beneficiary at any time by written (or electronic and telephonic) notice. If the Insured is a minor, his or her parent or guardian may exercise this right for him or her. The change will be effective when We or Our authorized agent receive it. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change. The Insured is the beneficiary for any covered Dependent.

Assignment: At the request of the Covered Person or his or her parent or guardian, if the Covered Person is a minor, medical benefits may be paid to the provider of service. Any payment made in good faith will end our liability to the extent of the payment.

Physical Examinations and Autopsy: We have the right to have a Physician of Our choice examine the Covered Person 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, unless the law forbids it. We will pay the cost of the examination or autopsy.

Legal Actions: No lawsuit or action in equity can be brought to recover on the Policy: 1. before 60 days following the date proof of loss was given to Us; or 2. After 3 years following the date proof of loss is required.

Recovery of Overpayment or Error: If benefits are overpaid, or paid in error, We have the right to recover the amount overpaid, or paid in error, by any or all of the following methods: 1. a request for lump sum payment of the amount overpaid, or paid in error. 2. Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error. 3. Taking any other action available to Us. We may at Our own expense take proceedings in the name of the Covered Person to recover compensation or secure an indemnity from any third party in respect of any loss, damage or expense covered by this Insurance and any amount so recovered or secured shall belong to Us.

Conformity with State Laws: On the effective date of the Policy, any provision that is in conflict with the laws in the state where it is issued is amended to conform to the minimum requirements of such laws.

Not in Lieu Of Workers' Compensation: The Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits.

Fraud Warning: If the Covered Person or any person acting on his/her behalf shall make any claim or statement knowing the same to be false or fraudulent as regards to amount or otherwise, then this Insurance shall become void and all claims here under shall be forfeited without refund of premium.