Notice to State of Washington Residents: This is not Your Description of Coverage. To obtain Your state-specific insurance policy, call 1.800.732.5309.

TRAVMED ABROAD

DESCRIPTION OF COVERAGE

For US Residents Traveling Outside the United States

This Insurance is underwritten by: ACE American Insurance Company, with its principal place of business in Philadelphia, PA.

Schedule of Basic Coverage and Services

Maximum Total Benefit for All Coverages	$100,000
Emergency Accident and Sickness Medical Expense Deductible per Injury or Sickness	$25
Emergency Dental sublimit	$200
Emergency Dental Deductible per Occurrence	$25
Medical Evacuation & Repatriation	100% of Covered Expenses
Repatriation of Remains	100% of Covered Expenses
Emergency Reunion	100% of Covered Expenses
Return of Dependent Children	100% of Covered Expenses
Worldwide Assistance Services	

Schedule of Optional Coverages
(can only be purchased with basic plan)

Benefit	**Maximum Limit**
Lost Baggage per person	$1,000
Deductible per occurrence	$100
Maximum Limit per Single Article	$250
Trip Cancellation & Interruption	$5,000

HOW TO USE TRAVMED ABROAD SERVICES

24 hours a day, 7 days a week, 365 days a year

If you have a medical or travel problem, simply call us for assistance. Our toll-free and collect-call telephone numbers are printed on your ID card. Either call the toll-free number of the country you are in, call collect, or email at:

Baltimore, Maryland +1-410-453-6330
Assistance@uhcglobal.com

A multilingual assistance coordinator will ask for your name, your company or group name if applicable, your MEDEX ID number found on your ID card, and a description of your situation. We will immediately begin assisting you. A full listing of services follows.

If the condition is an emergency, You should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. We will then take the appropriate action to assist You and monitor Your care until the situation is resolved.

Payments arranged by MEDEX:

Most Physicians and hospitals will provide you with the necessary medical treatment will either send their bill directly to MEDEX Insurance Services, or in the case of small dollar amounts, may ask You to pay at time services are rendered. Ask the hospital or Physician to contact MEDEX. We will confirm Your protection plan coverage and arrange for prompt payments. You will be asked to pay for any deductible amount or items not covered by Your plan.

Payments made by You:

If You are required to pay for medical treatment, obtain a signed receipt and a signed statement by a Physician describing the problem and the treatment. Once Your other insurance has processed Your claim, submit a copy of their final disposition along with a MEDEX Insurance Services claim form and a copy of Your receipts to:

MEDEX Insurance Services
8501 LaSalle Road, Suite 200
Baltimore, MD 21286
1-800-732-5309 or 1-410-453-6380

For claim forms or questions, call between 8:00 A.M. and 5:00 P.M. Monday through Friday Eastern Time.

MEDICAL PROTECTION

MEDICAL EXPENSE BENEFIT The Insurer will pay Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident or Sickness. These benefits are subject to the Deductibles, Benefit Periods, Benefit Maximums and other terms and/or limits shown in the Schedule of Benefits.

Medical Expense Benefits are only payable a) for Usual and Customary Charges incurred after the Deductible has been met; b) for those Medically Necessary Covered Expenses that the Covered Person incurs; and c) for charges incurred for services rendered to the Covered Person while traveling on a scheduled Trip . No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Covered Expenses include Confinement in a Hospital; Treatment by a Doctor; Services and supplies ordered by a Doctor; Care given by a graduate nurse; Ambulance service to and from the Hospital;. Prescription drugs prescribed by a Doctor and administered on an outpatient basis; Dental care due to Injury to sound, natural teeth.

Additional Exclusions: Coverage is not provided for 1) Routine physical examination and 2) hearing aids, eyeglasses, contact lenses, sunglasses, and artificial teeth.

In the event that the Covered Person is hospitalized beyond the date the insurance coverage terminates, the Insurer will continue to pay Medical Expense Benefits for Covered Medical Expenses until: a) the Covered Person is released from the hospital, or b) the maximum benefit is paid.

Dental Sublimit The Insurer will pay benefits, up to $200.00, for emergency dental treatment for Accidental Injury to sound natural teeth.

EMERGENCY MEDICAL EVACUATION The Insurer will pay Emergency Medical Evacuation Benefits as shown in the Schedule of Benefits for Covered Expenses incurred for the medical evacuation of a Covered Person. Benefits are payable up to the Maximum Benefit shown in the Schedule of Benefits if the Covered Person:

1. suffers a Medical Emergency during the course of the Trip;
2. requires a Medically Necessary Emergency Medical Evacuation; and
3. is traveling outside of their Home Country.

Covered Expenses:

1. **Medical Transport**: expenses for transportation under medical supervision to a different hospital, or treatment facility for Medically Necessary treatment in the event of the Covered Person's Medical Emergency and upon the request of the Doctor designated by Us in consultation with the local attending Doctor.
2. **Dispatch of a Doctor or Specialist**: the Doctor's or specialist's travel expenses and the medical services provided on location, if, based on the information available, a Covered Person's condition cannot be adequately assessed to evaluate the need for transport or evacuation and a Doctor or specialist is dispatched by Us to the Covered Person's location to make the assessment.
3. **Return of Dependent Child(ren):** expenses to return each Dependent child who is under age 18 to his or her principal residence, not to exceed the Benefit Maximum shown in the Schedule of Benefits, if a) the Covered Person is age 18 or older; and b) the Covered Person is the only person traveling with the minor Dependent child(ren); and c) the Covered Person suffers a Medical Emergency and must be confined in a Hospital.

Benefits for these Covered Expenses will not be payable unless a) the Doctor ordering the Emergency Medical Evacuation certifies the severity of the Covered Person's Medical Emergency requires an Emergency Medical Evacuation; b) all transportation arrangements made for the Emergency Medical Evacuation are by the most direct and economical conveyance and route possible; c) the charges incurred are Medically Necessary and do not exceed the Usual and Customary Charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and d) do not include charges that would not have been made if there were no insurance. Benefits will not be payable unless We authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance.

EMERGENCY REUNION BENEFIT In the event the Covered Person is or will be confined in a Hospital for at least 7 consecutive days due to a covered Injury or Sickness and is traveling alone, the Insurer will pay the expenses incurred for travel of a person chosen by him or her, up to the Benefit Limit shown in the Schedule of Benefits. Covered expenses are limited to a round-trip economy airline ticket. All travel arrangements must be made by Us and approved in advance in order for expenses to be considered eligible.

MEDICAL REPATRIATION BENEFIT The Insurer will pay expenses incurred for medical repatriation after a hospitalization or medical treatment for a Covered Accident or Sickness, if the Covered Person is (a) unable to continue his or her Trip as recommended by the treating doctor in consultation with Us or (b) if it is Medically Necessary for the Covered Person to return home for continued medical treatment.

We will coordinate with the local attending Doctor to arrange the Covered Person's return to his or her Home Country. We will provide the appropriate medical personnel to accompany the Covered Person during the return Trip if it is Medically Necessary.

Covered Expenses include transportation, medical treatment, medical services and medical supplies incurred in connection with a Covered Person's repatriation. All transportation arrangements made for repatriating the Covered Person must be by the most direct and economical route possible. Expenses for transportation must be: (a) recommended by the local attending Doctor; (b) required by the standard regulations of the conveyance transporting the Covered Person; and (c) arranged and authorized in advance by Us. The expenses paid will be less the value of any unused ticket.

If We and the local attending Doctor determine the Covered Person is eligible for medical repatriation; but the Covered Person refuses to be repatriated, We will not be liable for any medical expenses incurred after the date medical repatriation is refused.

REPATRIATION OF REMAINS BENEFIT The Insurer will pay Repatriation Benefits as shown in the Schedule of Benefits for preparation and return of a Covered Person's body to his or her home if he or she dies as a result of a Medical Emergency while traveling outside of his or her Home Country. Covered Expenses include expenses for embalming or cremation; the minimally necessary coffin or receptacle adequate for transporting the remains; transporting the remains; and documentation fees.

All transportation arrangements must be made by the most direct and economical route and conveyance possible and may not exceed the Usual and Customary Charges for similar transportation in the locality where the expense is incurred. Benefits will not be payable unless We authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance.

OPTIONAL COVERAGES

TRIP CANCELLATION AND INTERRUPTION BENEFIT

The Insurer will pay this Primary benefit up to the Maximum Limit shown in the Schedule of Benefits if a trip is delayed, cancelled or interrupted for the Covered Person, due to any of the following Unforeseen reasons:

1. Sickness, Injury, or death of a Covered Person or Traveling Companion. Injury or Sickness must be so disabling as to reasonably cause a Trip to be delayed, canceled, or interrupted. If the Covered Person must cancel or interrupt the Trip due to Injury or Sickness of a Family Member, it must be because their condition is life threatening, or because the Family Member requires the Covered Person's care. Cancellation due to the death of a Family Member is covered only if the death occurs within 30 days of the Covered Person's Scheduled Departure Date.
2. the Covered Person's Home/primary residence being made uninhabitable by fire, flood, vandalism, burglary or natural disaster.
3. the Covered Person or a Traveling Companion/Family Member being subpoenaed, required to serve on jury duty; hijacked or be quarantined or required by a court order to appear as a witness in a legal action, provided the Covered Person, a Family Member traveling with the Covered Person, or a Traveling Companion is not 1) a party to the legal action, or 2) appearing as a law enforcement officer.
4. being directly involved in or delayed due to a traffic accident en route to departure.
5. military duty having leave revoked or being reassigned within 10 days of departure date.
6. being called into active military service to provide aid or relief in the event of a natural disaster.
7. a Terrorist Incident in a foreign city to which the Covered Person was scheduled to arrive within 30 days following the incident.
8. an employer-initiated transfer of employment within the same organization of 250 miles or more.
9. cancellation of scheduled public transportation as a result of: riot, civil commotion, Strikes, hijacking, natural disasters, motor or railway accidents that were unknown at the time of booking the reservation.

"Covered Expenses" means:

1. before the Scheduled Departure Date, the lesser of:
   a. the cancellation charges imposed by a Travel Supplier for the Trip;
   b. the cost of substituting a travel arrangement not provided due to the Financial Insolvency of a Travel Supplier to enable the Covered Person to take the Trip; and
   c. all sums prepaid to Travel Suppliers for the Trip that become non-recoverable due to the Financial Insolvency of a Travel Supplier; or
2. after the Scheduled Departure Date:
   a. the greater of either:
      i. the amount of the unused, non-refundable prepaid air arrangements which formed a part of the Covered Person's Trip; or

ii. the fare paid, less the value of applied credit from the unused travel tickets, to return to the Covered Person's place of permanent residence or to continue a Trip limited to the cost of one-way Economy Airfare, by a scheduled carrier from the Destination point to the point of origin shown on the original travel tickets; and

b. the cost of any unused, non-refundable Land and Sea Arrangements prepaid to the Travel Supplier for the Covered Person's Trip.

BAGGAGE AND TRAVEL DOCUMENTS BENEFIT

The Insurer will reimburse benefits up to the Maximum Limit shown in the Schedule of Benefits subject to a $100 Deductible per loss. The Insurer will pay for all direct loss due to accident to the Covered Person's Baggage, passports and visas, during the Covered Person's Trip, while checked with a Common Carrier.

Continuation of Coverage: If the covered Baggage, passports and visas are in the charge of a charter or Common Carrier, and delivery is delayed, this coverage will continue until such property is delivered to the Covered Person. This coverage does not include loss caused by the delay.

Destroyed/Damaged Baggage: The Insurer will reimburse the Covered Person up to the maximum shown in the Schedule of Benefits for damage to Baggage on a Common Carrier during the Trip. The Insurer will pay the lesser of the following: the original cash value of the item less depreciation as determined by Us; or the cost of repair or replacement limit per articles - $250. If receipts are not provided, benefits may be reduced.

Lost Baggage: The Insurer will reimburse the Covered Person up to the maximum shown in the Schedule of Benefits for loss of Baggage on a Common Carrier during the Trip.

The Insurer will pay the lesser of the following: the original cash value of the item less depreciation as determined by Us; or the cost of repair or replacement limit per articles - $250. There will be a combined maximum limit of $500 for the following: jewelry, watches, articles consisting in whole or in part of silver, gold, or platinum; furs and articles trimmed with or made mostly with fur. This benefit includes the contents of the Baggage.

Payment of Loss: We will pay the lesser of the cost to repair an item, or to replace it with an item of like kind and quality. We will pay, in cash, the cost of repair or replacement of the Covered Person's damaged Baggage, less depreciation; or at Our option repair or replace the Covered Person's Baggage.

WORLDWIDE EMERGENCY ASSISTANCE SERVICES

MEDICAL ASSISTANCE SERVICES

Worldwide Medical and Dental Referrals: MEDEX will provide referrals to help You locate appropriate treatment and quality care.

Monitoring of Treatment: MEDEX case managers will continually monitor Your case. In addition, MEDEX Physician Advisors provide consultative and advisory services, including review and analysis of the quality of medical care You are receiving.

Facilitation of Hospital Payment: Upon securing payment or a guarantee to reimburse, MEDEX will either wire or guarantee funds needed for hospital admittance costs. You are ultimately responsible for the payment of the cost of medical care and treatment, including hospital expenses or wiring fees.

Transfer of Insurance Information to Medical Providers: MEDEX will relay insurance benefit information to help prevent delays or denials of medical care. MEDEX will also assist with hospital admission and discharge planning.

Transfer of Medical Records: Upon Your consent, MEDEX will assist with the transfer of medical information and records to You or the treating physician.

Medication and Vaccine Transfers: In the event medication or vaccines are not available locally, or a prescription medication is lost or stolen, MEDEX will make best commercial efforts to coordinate their transfer to You upon the prescribing physician's authorization, if it is legally permissible. You will be responsible for the cost of the medication or vaccine and any delivery costs.

Updates to Family, Employer, and Home Physician: With Your approval, MEDEX will provide periodic case updates to appropriate individuals You designate in order to keep them informed.

Hotel Arrangements: MEDEX will assist You with the arrangement of hotel stays and room requirements before or after hospitalization or for ongoing care. You are responsible for costs of lodging and incidental expenses.

Replacement of Corrective Lenses and Medical Devices: MEDEX will coordinate the replacement of corrective lenses or medical devices if they are lost, stolen, or broken during travel. You will be responsible for the cost of the item and any delivery costs.

TRAVEL ASSISTANCE SERVICES

Replacement of Lost or Stolen Travel Documents: MEDEX will assist You in taking the necessary steps to replace passports, tickets, and other important travel documents.

Emergency Travel Arrangements: MEDEX will make new reservations for airlines, hotels, and other travel services in the event of an Illness or Injury or Emergency Security Situation.

Transfer of Funds: MEDEX will provide You with an emergency cash advance subject to first securing funds from You or Your family. You are responsible for any fees for the wiring of these funds.

Legal Referrals: Should You require legal assistance, MEDEX will direct You to an attorney.

Language Services: MEDEX multilingual case managers are available to provide immediate interpretation assistance in a variety of languages in an emergency; otherwise MEDEX will provide You with referrals to interpreter services. Written translations and other custom requests, including an on-site interpreter will be subject to an additional fee.

Message Transmittals: You may send and receive emergency messages toll-free, 24-hours a day, through MEDEX Emergency Response Center.

WORLDWIDE DESTINATION INTELLIGENCE

Pre-Travel Information: Upon Your request, We can provide updated destination intelligence for 173 countries covering subject areas such as weather, currency and culture.

Travel and Health Information: Upon Your request We can provide You with updates on travel and health information such as immunizations, vaccinations, regional health concerns, entry and exit requirements, and transportation information.

Security Intelligence: Upon Your request, We will provide You with the latest authoritative information and security guidance for over 173 countries and 283 cities. Our global security database is continuously updated and includes intelligence from thousands of worldwide sources.

SCOPE OF COVERAGE

Excess Coverage The benefits payable under the Policy, except for Accidental Death and Dismemberment Benefit, will only be paid on an excess basis over and above any benefits or services provided for by: a) any other valid or collectible insurance; or b) any other form of indemnity payable by those responsible for the loss, such as an airline.

GENERAL EXCLUSIONS

Pre-existing Medical Condition Exclusion Applicable To All Coverages (Except Emergency Medical Evacuation and Repatriation of Remains) The Policy will not pay for loss or expense incurred as the result of Injury or Sickness of the Covered Person which manifests itself during the 6 months immediately preceding and including the Effective Date, unless the condition is controlled through the taking of prescription drugs or medication and remains controlled (without any change) throughout the 6 month period.

In addition to any exclusion which applies to a particular benefit (called "Additional Exclusions"), the Policy does not cover loss due to:

1. traveling expressly for the purpose of obtaining medical treatment.
2. intentionally self-inflicted Injury, suicide, or attempted suicide, while sane or insane (in Missouri, while sane).
3. war or any act of war, whether declared or not, civil disturbance or insurrection.
4. military duty or service; while serving as a member of the naval, air or Armed Services of any country.
5. piloting or serving as a crewmember or riding in any Aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
6. mental, psychological or nervous disorders including anxiety, depression, neurosis or psychosis.
7. participation in professional athletic events.
8. any non-emergency treatment or surgery.
9. Injury or loss or Sickness that occurs while the Covered Person is legally intoxicated (as determined by that state's law) or while under the influence of any drug unless administered under the advice and consent of a Doctor.
10. commission of, or attempt to commit, a felony, an assault or other criminal activity.

11. bungee-cord jumping, parachuting, skydiving, parasailing, hang-gliding, mountaineering (the ascent or descent of a mountain requiring the use of specialized equipment, including, but not limited to, pick-axes, anchors, bolts, crampons, carabineers and lead or top-rope anchoring equipment), any race, scuba diving and speed contest.
12. pregnancy or childbirth, other than Complications of Pregnancy.
13. replacement of hearing aids unless a covered Injury has caused impairment of hearing.
14. replacement of eyeglasses or contact lenses, or eye examinations for the correction of vision or fitting of glasses unless a covered Injury has caused impairment of sight.
15. Injury or Sickness where the Covered Person is traveling against the advice of a medical professional.

If We determine the benefits paid under this Policy are eligible benefits under any other benefit plan, We may seek to recover any expenses covered by another plan to the extent that the Covered Person is eligible for reimbursement.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

The following exclusions apply only to the Baggage and Travel Documents Benefit in the Optional Coverages section:

Property Not Covered: The Insurer will not pay for damage or loss of: animals; bicycles except when checked with a Common Carrier; motor vehicles and equipment, boats, motorcycles, motors or any other vehicles; artificial limbs, artificial teeth, dental bridges/appliances, any type of eyeglasses, sunglasses or contact lenses; hearing aids; tickets, keys, money, notes, securities, accounts, bills, currency, deeds, food stamps or other evidence of debt, credit cards and other travel documents except passports and visas; money, stamps, stocks and bonds, postal or money orders; credit cards, except as noted above; household furniture or furnishings; business samples/items; sporting equipment if loss or damage results from the use thereof; property used in trade, business or for the production of income.

Additional Exclusions: The Insurer will not pay this benefit for loss due to: normal wear and tear; gradual deterioration; rodents, animals or insects; damage while being worked on; natural defect or damage sustained due to any process or repair; civil war, insurrection, rebellion, revolution or warlike act by a military force, whether war is declared or not declared; confiscation or expropriation by order of any government; nuclear reaction, nuclear radiation, or radioactive contamination; sporting equipment damaged while being used; theft or pilferage while left unattended in any vehicle; mysterious disappearance.

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

“Common Carrier” means a vehicle or service licensed to carry passengers for hire on a regularly scheduled basis.

“Complication of Pregnancy” means a condition requiring Hospital confinement, whose diagnosis is distinct from pregnancy but adversely affected or caused by pregnancy, such as: a) acute nephritis or nephrosis; b) cardiac decompensation; c) missed abortion; and d) similar medical and surgical conditions of comparable severity. Complications of Pregnancy will also include: a) non-elective cesarean section; b) termination of ectopic pregnancy; and c) spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible. However, the term Complication of Pregnancy will not include: a) false labor, occasional spotting, or morning sickness; b) Doctor prescribed rest; c) hyperemesis gravidarum; d) pre-eclampsia; or any similar condition associated with the management of a difficult pregnancy not consisting of a nosologically distinct Complication of Pregnancy.

“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 Person” means any eligible person, including Dependents if eligible for coverage under the Policy, who applies for coverage and for whom the required Premium is paid. If the cost for this insurance is paid for by the {Participating Organization/Policyholder}, individual applications are not required for an eligible person to be a Covered Person.

“Covered Trip” means a) A period of round-trip travel away from Home to a Destination outside of the Covered Person’s Home Country; the purpose of the trip is business or pleasure and is not to obtain health care or treatment of any kind; the trip has defined departure and return dates specified when the Covered Person applies; the trip does not exceed 90 days; or b) A period of one-way travel that starts in the U.S. (except U.S. citizens may begin their trip outside the U.S., if returning to the U.S.); the purpose of the trip is business or pleasure and is not to obtain health care or treatment of any kind; the trip has defined departure and arrival dates and defined departure and arrival places specified when the Covered Person applies; and the trip does not exceed 90 days in length.

In this policy, Covered Trip is also referred to as “Trip”.

“Deductible” means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person before benefits are payable under the Policy.

“**Dependent**” means an Insured’s lawful Spouse; Domestic Partner; or an Insured’s unmarried child, from the moment of birth to age 19, 25 if a full-time student, 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 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 mainly 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.
If the Insured has elected coverage for a Dependent child, any newly born child of the Insured will be covered from the moment of birth for 31 days. Coverage may be continued beyond this time period if the Insured notifies Us within 31 days of the child's birth and pays any required Premium.
"**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.
"**Domestic Partner**" means a person of the same or opposite sex of the Covered Person who:

1. shares the Covered Person's primary residence;
2. has resided with the Covered Person for at least 6 months prior to the date of enrollment and is expected to reside with the Covered Person indefinitely;
3. is financially interdependent with the Covered Person in each of the following ways;
    a. by holding one or more credit or bank accounts, including a checking account, as joint owners;
    b. by owning or leasing their permanent residence as joint tenants;
    c. by naming, or being named by the other as a beneficiary of life insurance or under a will;
    d. by each agreeing in writing to assume financial responsibility for the welfare of the other.
4. has signed a Domestic Partner declaration with the Covered Person, if recognized by the laws of the state in which they reside;
5. has not signed a Domestic Partner declaration with any other person within the last 12 months.
6. is older than 18 years old;
7. is not currently married to another person;
8. is not in a position as a blood relative that would prohibit marriage.

"**Economy Airfare**" means the lowest published rate for a one-way ticket.
"**Family Member**" means a) the Covered Person's Traveling Companion(s); and b) the Covered Person's or Traveling Companion's: 1) Spouse; 2) child; 3) parent; 4) sibling; 5) grandparent or child; 6) step-parent, child or sibling; 7) son- or daughter-in-law; 8) parents-in-law; 9) brother- or sister-in-law; 10) aunt; 11) uncle; 12) niece or nephew; 13) legal guardian; 14) legal ward; 15) Domestic Partner.
"**Financial Insolvency**" means a Travel Supplier has ceased operations either after filing a petition for bankruptcy or as a result of a denial of credit or inability to meet financial obligations.
"**Home Country**" means a country from which the Covered Person holds a passport or greencard. If the Covered Person holds passports or greencards from more than one country, his or her Home Country will be that country which the Covered 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 Doctors available at all times; 4) provide 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 for drug addicts, alcoholics, or the aged.
"**Injury**" means accidental bodily harm sustained by a Covered Person that results directly and independently from all other causes from a Covered Accident. The Injury must be caused solely through external, violent and accidental means. All Injuries sustained by one person in any one Covered Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.
"**Insurer**" means ACE American Insurance Company.
"**Medical Emergency**" means a condition caused by an Injury or Sickness that manifests itself during the Covered Trip which requires immediate and emergent medical treatment not available in the Covered Person's location and without which there would be a significant risk of death or serious impairment.
"**Medically Necessary**" means a treatment, service or supply that is: 1) required to treat an Injury; prescribed or ordered by a Doctor or furnished by a Hospital; 3) performed in the least costly setting required by the Covered Person's condition; and 4) 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 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 Covered Expense.
"**Pre-existing Condition**" means – an illness, disease or other condition of the Insured, that in the 6-month period before the Insured's coverage became effective under this Policy:

1. first manifested itself, worsened, became acute or exhibited symptoms that would have caused an ordinarily prudent person to seek diagnosis, care or treatment; or
2. required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or
3. was treated by a Doctor or treatment had been recommended by a Doctor.

"**Scheduled Departure Date**" means the date on which the Covered Person is scheduled to leave on his or her Trip. This date is shown on the Covered Person's Application.
"**Sickness**" means an illness, disease or condition of the Covered Person that occurs during the Trip, and requires treatment by a Doctor. Sickness includes Complications of Pregnancy.
"**Transportation**" means any land, water, or air conveyance required to transport the Covered Person during an Emergency Evacuation.
"**Travel Supplier**" means the Tour operator, cruise line or airline providing prepaid travel arrangements for a Trip. Travel Supplier does not mean the person, organization or firm from whom the Covered Person directly purchased and paid for the Covered Person's Trip.
"**Traveling Companion**" means a person who accompanies the Covered Person on the entire trip.
"**Unforeseen**" means not anticipated or expected and occurring after the effective date of the Covered Person's coverage.
"**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 MEDEX Insurance Services.

EFFECTIVE DATE OF INSURANCE

After Premium is paid by the Covered Person and the Application is completed and signed, TRIP CANCELLATION AND INTERRUPTION BENEFIT will be effective:
1. at 12:00 a.m. (midnight) on the day after the Application is postmarked to Us if coverage is purchased by mail; or
2. at 12:00 a.m. (midnight) on the day after the Application is phoned in to Us if coverage is purchased by phone; or
3. at 12:00 a.m. (midnight) on the day after the Application is faxed to Us if coverage is purchased by facsimile;
4. at 12:00 a.m. (midnight) on the day after the online purchase confirmation date;
5. on the day after the Application is completed online.

All other coverages will begin on the later of:
1. the date and time the Covered Person starts his or her trip, or
2. the scheduled Trip Departure Date shown on the Application;
3. the date after the Premium is paid.

TERMINATION DATE OF INSURANCE

All coverage ends on earliest of:
1. the date the Trip is completed; or
2. the scheduled Trip Completion Date shown on the individual Application; or
3. cancellation of the Trip covered by the Policy; or
4. upon arrival in the United States.

CLAIM PROVISIONS

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.
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, should proof of loss be sent later than one year from the time proof is otherwise required.
Payment Of Claims: If the Insured dies, any death benefits or other benefits unpaid at the time of the Insured's death will be paid to the beneficiary Our records indicate the Insured designated for these plan benefits.
If there is no named beneficiary or surviving beneficiary on record with Us or Our authorized agent, We pay benefits in equal shares to the first surviving class of the following:
1. Spouse;
2. Children;
3. Parents;
4. Brothers and sisters.

If there are no survivors in any of these classes, We will pay the Insured's estate.

All other benefits will be paid to the Insured. If the Insured is: (1) a minor; or (2) in Our opinion unable to give a valid release because of incompetence, We may pay any amount due to a parent, guardian, or other person actually supporting him or her. Any payment made in good faith will end Our liability to the extent of the payment.
Assignment: At the request of the Insured or his or her parent or guardian, if the Insured 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 Doctor 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 before 60 days following the date proof of loss was given to Us. No such action can be brought after expiration of the applicable statute of limitations from the time written proof of loss is required to be furnished.

GENERAL PROVISIONS

Entire Contract; Changes: The Policy (including any endorsements or amendments), the signed application of the Policyholder, and any individual applications of Covered Persons, are the entire contract. Any statements made by the Policyholder or Covered Persons will be treated as representations and not warranties. No such statement shall void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.
To be valid, any change or waiver must be in writing (or authorized electronic or telephonic communications). It must be signed by Our President or Secretary and be attached to the Policy. No agent has authority to change or waive any part of the Policy.
Policy Effective Date And Termination Date: The Policy begins on the Policy Effective Date at 12:00 a.m. (midnight) at the address of the Policyholder where this Policy is delivered. We may terminate this Policy by giving 31 days advance notice in writing (or authorized electronic or telephonic means) to the Policyholder. This Policy may be terminated at any time by mutual written or authorized electronic/telephonic consent of the Policyholder and Us. This Policy terminates automatically on the earlier of: 1) the last day of the Policy Term; or 2) the Premium due date if Premiums are not paid when due. Termination takes effect at 12:00 a.m. (midnight) at the Policyholder's address on the date of termination.
Clerical Error: If a clerical error is made, it will not affect the insurance of any Covered Person. No error will continue the insurance of a Covered Person beyond the date it should end under the Policy terms.
Examination Of Records And Audit: We shall be permitted to examine and audit the Policyholder’s books and records at any time during the term of the Policy and within 2 years after the final termination of the Policy as they relate to the premiums or subject matter of this insurance.
Conformity With State Laws: On the effective date of this 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.
Subrogation: We may recover any benefits paid under the Policy to the extent a Covered Person is paid for the same Injury or Sickness by a third party, another insurer, or the Covered Person’s uninsured motorist insurance. We may only be reimbursed to the amount of the Covered Person’s recovery. Further, We have the right to offset future benefits payable to the Covered Person under the Policy against such recovery.
We may file a lien in a Covered Person’s action against the third party and have a lien on any recovery that the Covered Person receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. We shall have a right to recovery of the full amount of benefits paid under the Policy for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Covered Person. We will not be responsible for the Covered Person’s attorney’s fees or other costs.
Upon request the Covered Person must complete the required forms and return them to Us or Our authorized agent. The Covered Person must cooperate fully with Us or Our representative in asserting its right to recover. The Covered Person will be personally liable for reimbursement to Us to the extent of any recovery obtained by the Covered Person from any third party. If it is necessary for Us to institute legal action against the Covered Person for failure to repay Us, the Covered Person will be personally liable for all costs of collection, including reasonable attorneys’ fees.

STATE EXCEPTIONS

The following is applicable in Florida:
a.) The Excess Insurance Provision is deleted.
b.) *Definitions*: The definition of Dependent is replaced with the following:
“**Dependent**” means an Insured’s lawful Spouse or Domestic Partner under age 70; or an Insured’s child, from the moment of birth to the end of the calendar year in which the child reaches age 25 if the child is:

1. chiefly dependent on the Insured for support;
2. living in the Insured’s household, or is a full-time or part-time student.

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; foster child; a child in court ordered or other custody of the Insured; or a stepchild who resides with the Insured or depends 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 MAINLY 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.
The Insured has the option to insure his or her child at least until the end of the calendar year in which the child reaches the age of 30, if the child:

1. is unmarried and does not have a Dependent of his or her down;
2. is a resident of Florida or a full-time or part-time student; and
3. is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

If the Insured has elected coverage for a Dependent child, any newly born child of the Insured will be covered from the moment of birth for 31 days. Coverage may be continued beyond this time period if the Insured notifies Us within 31 days of the child's birth and pays any required Premium.
c.) *Definitions*: The definition of Domestic Partner is replaced with the following:
"**Domestic Partner**" means any natural person qualifying as such under the provision of any federal, state or local law.
d.) *Definitions*: The definition of Hospital is replaced with the following:
"**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 Doctors available at all times; 4) provide 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 for drug addicts, alcoholics, or the aged.
e.) *Definition*: The definition of Injury is replaced with the following:
"**Injury**" means accidental bodily harm sustained by a Covered Person from a Covered Accident which is the direct cause, independent of disease or bodily infirmity, of the covered loss. All injuries sustained by one person in any one Covered Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.
f.) *Exclusions*: The Pre-existing Conditions exclusion period is amended to 90 days.
g.) *General Provisions*: The following provisions are added:
Crime Victims Provision: If the Covered Person is a victim of a violent crime and it is determined that the Covered Person is eligible under the Florida Crimes Compensation Act, any deductible and coinsurance provision of this Policy will not apply. The Covered Person must provide Us with a copy of the written notification concerning his or her status received from the Office of the Attorney General, Division of Victim Services, State of Florida.
Fraudulent Claims: The making by the Covered Person of any fraudulent claims shall render this Policy null and void from the Effective Date and all claims under this Policy shall be forfeited.
h.) *General Provisions*: The following provisions are amended as follows:
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 unless the designation of the beneficiary is irrevocable. 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.
Legal Actions: No lawsuit or action in equity can be brought to recover on the Policy before 60 days following the date Proof of Loss was given to Us. No such action can be brought after expiration of the applicable statute of limitations from the time written Proof of Loss is required to be furnished.
Entire Contract; Changes: The Policy (including any endorsements or amendments) and the signed application of the Insured (if any) are the entire contract. Any statements made by the Insured will be treated as representations and not warranties. No such statement shall void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application. A copy of the signed application will be furnished to the Insured.

The following is applicable in Georgia:
a.) The Excess Insurance Provision is deleted.
b.) *General Provisions*: The Subrogation provision is deleted.
c.) *Definitions*: The definitions of Domestic Partner, Financial Insolvency, and Unforeseen are all deleted.
d.) *Definitions*: The following definitions are replaced as follows:
"**Complication of Pregnancy**" means a condition requiring Hospital confinement, whose diagnosis is distinct from pregnancy but adversely affected or caused by pregnancy, such as: a) acute nephritis or nephrosis; b) cardiac decompensation; c) missed abortion; and d) similar medical and surgical conditions of comparable severity.

Complications of Pregnancy will also include: a) non-elective cesarean section; b) termination of ectopic pregnancy; and c) spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible. However, the term Complication of Pregnancy will not include: a) false labor, occasional spotting, or morning sickness; b) Doctor prescribed rest; c) hyper emesis gravid arum; or any similar condition associated with the management of a difficult pregnancy not consisting of a nosologically distinct Complication of Pregnancy.

"**Dependent**" means an Insured's lawful Spouse under age 75; or an Insured's unmarried child, from the moment of birth to age 19, 26 if a full-time student, who is chiefly dependent on the Insured for support. A full-time student is one who is enrolled for five calendar months or more as a full-time student in a postsecondary institution of higher learning, or if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to illness or injury. A child, for eligibility purposes, includes an Insured's:

1. natural child;
2. adopted child, or child placed for adoption, beginning with the date of placement for adoption, or final decree of adoption, whichever occurs first;
3. a stepchild who resides with the Insured or depends on the Insured for financial support; and
4. any child who is related to the Insured without regard as to whether the child:
   a) was born out of wedlock; or
   b) is claimed as a dependent on the Insured's federal tax return.

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 INCAPABLE OF SELF-SUSTAINING EMPLOYMENT BY REASON OF MENTAL RETARDATION OR PHYSICAL DISABILITY AS DETERMINED BY THE DEPARTMENT OF HUMAN RESOURCES; AND
2. THE CHILD DEPENDS MAINLY ON THE INSURED FOR SUPPORT AND MAINTENANCE.

THE INSURED MUST GIVE US PROOF THAT THE CHILD MEETS THESE CONDITIONS WITHIN 31 DAYS OF THE CHILD'S ATTAINMENT OF THE LIMITING AGE, AND SUBSEQUENTLY AS REQUIRED BY US. WE WILL NOT ASK FOR PROOF MORE THAN ONCE A YEAR AFTER THE TWO-YEAR PERIOD FOLLOWING THE CHILD'S ATTAINMENT OF THE LIMITING AGE.

A CHILD DEPENDENT ON THE OTHER PARENT IS CONSIDERED AN ELIGIBLE DEPENDENT. THE PROPORTION OF THE CHILD'S SUPPORT THAT THE INSURED PROVIDES DOES NOT AFFECT THE CHILD'S ELIGIBILITY FOR COVERAGE.

If the Insured has elected coverage for a Dependent child, any newly born child, adopted child, or a child placed for adoption of the Insured will be covered from the moment of birth for 31 days. Coverage may be continued beyond this time period if the Insured notifies Us within 31 days of the child's birth and pays any required Premium.

"**Family Member**" means a person who is related to the Covered Person in any of following ways: spouse; parent (includes stepparent); child (includes legally adopted and step child); brother or sister (includes stepbrother or stepsister); parent-in-law; son- or daughter–in–law; and brother- or sister-in-law.

Family Member also means the Insured's Business Partner. Business Partner means someone who is a majority stockholder, managing officer, or majority owner of the company.). They all must reside in the U.S. or Canada at the time of purchase of the Policy.

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

"**Usual and Customary Charge**" means the normal charge, in the absence of insurance, of the provider for a service or article, but not more than the prevailing charge in the area for like service or article. A "like service" is the same nature and duration, requires the same skill, and is performed by a provider of similar training and experience. A "like article" is one that is identically or substantially equivalent. "Area" means the municipality or, in the case of a large city, a subdivision of the city, in which the service or article is actually provided or a greater area as is necessary to obtain a representative cross-section of charges for like service or article.

"**We", "Our", "Us"** means ACE American Insurance Company.

e.) *General Provisions*: The following provisions are replaced:

Notice Of Claim: A claimant must give Us or Our authorized representative written (or authorized electronic or telephonic) notice of claim within 20 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.

Claim Forms: Upon receiving written notice of claim, We will send claim forms to the claimant within 10 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.

Proof Of Loss: Written (or authorized electronic or telephonic) proof of loss must be sent to Us or 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. In the case of a claim for Loss for which this Policy provides any periodic payment contingent upon continuing Loss, proof of

loss must be sent within 90 days after the termination of the period for which We are liable. If it cannot be provided within that time, it should be sent as soon as reasonably possible. Failure to furnish proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. 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.

Payment Of Claims: If the Insured dies, any death benefits or other benefits unpaid at the time of the Insured'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 Insured'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 Insured, if living.

Otherwise, the benefits may, at our option, be paid:

1. according to the beneficiary designation; or
2. to the Insured's estate.

If a benefit due is payable to:

1. the Insured's estate; or
2. the Insured or a beneficiary who is either a minor or is not competent to give a valid release for the payment,

We may pay an amount not exceeding $1,000 to any relative by blood or connection by marriage of the Insured or beneficiary who we believe is entitled to the payment. 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 Insured requests otherwise in writing. The Insured must make the request no later than the time he or she files a written proof of loss.

All benefit payments under this Policy will be made in the United States of America in the currency of the United States of America.

f.) *General Provisions*: The following provision is added:

Simultaneous Death Provision: If the Insured and the beneficiary designated on the application for insurance have both died and there is not sufficient evidence that they have died otherwise than simultaneously, benefits payable under this Policy will be distributed as if the Insured had survived the beneficiary unless otherwise specifically provided for in this Policy. Payment made in accordance with this provision will fully discharge Us from all claims under the Policy unless, before payment is made, We have received at Our home office written notice by or on behalf of some other person that the person claims to be entitled to the payment or some interest in this Policy.

The following is applicable in Idaho:

a.) The Excess Insurance Provision is deleted.

b.) *General Provisions*: The Subrogation provision is deleted.

c.) *Definitions*: The following definitions are replaced as follows:

"**Dependent**" means an Insured's lawful Spouse; or an Insured's unmarried child, from the moment of birth to age 19, 25 if a full-time student, 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 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 1) IS INCAPABLE OF SELF-SUSTAINING EMPLOYMENT BECAUSE OF A MENTAL OR PHYSICAL HANDICAP; 2) WAS INCAPACITATED AND INSURED UNDER THE POLICY ON THE DATE HE OR SHE REACHES THE MAXIMUM AGE; AND 3) CONTINUES TO BE INCAPACITATED. YOU MUST SEND US SATISFACTORY PROOF OF THE HANDICAP WITHIN {30 TO 60 DAYS} OF THE CHILD REACHING THE MAXIMUM AGE FOR INSURANCE TO CONTINUE.

If the insured has elected coverage for a dependent child, any newly born child of the insured will be covered from the moment of birth for 60 days. Coverage may be continued beyond this time period if the insured notifies us within 60 days of the child's birth and pays any required premium.

"**Doctor**" means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to an Insured that is appropriate for the conditions and locality.

"**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 or under the supervision of Registered Nurses on duty or call; 3) has a staff of one or more licensed Doctors available at all times; 4) provide 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; 6) is not a place for drug addicts, alcoholics, or the aged; and 7) is not a military or veterans' hospital, a soldiers' home or a hospital contracted for or operated by any national government or government

agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability for the patient exists for charges made to the individual for the services.
We will not deny a claim for services rendered in any one of the following Hospitals 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:

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

"**Injury**" means accidental bodily harm sustained by a Covered Person that results directly and independently from all other causes from a Covered Accident. The Injury must be caused solely through accidental means. All Injuries sustained by one person in any one Covered Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.
"**Medically Necessary**" means health care services or products that a prudent Doctor would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease, or its symptoms in a manner that is a) in accordance with generally accepted standards of medical practice; b) clinically appropriate in terms of type, frequency, extent, site, and duration; and c) not primarily for the convenience of the patient, Doctor, or other health care provider.
"**Usual and Customary Charge**" means the normal charge, in the absence of insurance, of the provider for a service or article, but not more than the prevailing charge in the area for like service or article. A "like service" is the same nature and duration, requires the same skill, and is performed by a provider of similar training and experience. A "like article" is one that is identically or substantially equivalent. "Area" means the municipality or, in the case of a large city, a subdivision of the city, in which the service or article is actually provided or a greater area as is necessary to obtain a representative cross-section of charges for like service or article.
d.) *Emergency Medical Expense Benefit:* The exclusions are replaced with the following:

1. services for which no charge is normally made;
2. dental care or treatment, except for such care or treatment due to accidental Injury to sound, natural teeth;
3. pregnancy or childbirth, other than Complications of Pregnancy;
4. any expenses incurred due to a Pre-existing Condition, except for congenital anomalies of a covered Dependent child; (NOTE: This exclusion does not apply if the Pre-existing Conditions Waiver applies);
5. eyeglasses, hearing aids, and examination for the prescription or fitting thereof;
6. cosmetic surgery, except reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child;
7. services performed by a member of the Covered Person's Immediate Family;
8. rest cures and custodial care and transportation costs.
9. Elective abortion. "Elective abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed
10. Elective Treatment, or medical treatment during or arising from a Trip undertaken for the purpose or intent of securing medical treatment.
11. Injury or Sickness covered by Worker's Compensation or similar law, or any welfare plan operated by city, state or national government, except Medicaid.
12. replacement of hearing aids unless a covered Injury has caused impairment of hearing.
13. routine physical examinations.

e.) *Exclusions*: The general exclusions are replaced as follows:

1. intentionally self-inflicted Injury, suicide, or attempted suicide.
2. participation in sports.
3. war or any act of war, whether declared or not.
4. service in the military, naval pr air service of any country.
5. piloting or serving as a crewmember or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
6. participation in a felony.
7. commission of or active participation in a riot or insurrection.
8. civil disorder or riot.
9. mental or emotional disorders.
14. alcoholism or drug addiction.
10. Pre-existing Conditions.
11. Injury or loss or Sickness that occurs while the Covered Person is legally intoxicated (as determined by that state's law) or while under the influence of any drug unless administered under the advice and consent of a Doctor.
12. military duty or service while serving as a member of the naval, air or Armed Services of any country.

The following is applicable in Kansas:
a.) The Excess Insurance Provision is deleted.

b.) *Definitions*: The definition of “Dependent” is modified to cover dependent children for the first 31 days after birth or adoption.
c.) *Definitions*: The definition of “Doctor” is amended to read “any licensed health care provider”.
d.) *Definitions*: The definition of “Medically Necessary” is modified to remove “performed in the least costly setting required by the Covered Person’s condition”.
e.) *Definitions*: The definition of “Usual and Customary Charge” is replaced with:
“means the most frequently charged fee, in the absence of insurance, of the health care provider in the same geographic locality for a comparable supply or service. We will determine the Usual and Customary Charge based on the Medical Data Research (MDR) survey of prevailing fees, updated every six months on the basis of the most current codes and nomenclature developed and maintained by MDR.”
f.) *General Provisions*: Time of Payment of Claims is replaced with the following:
“Benefits payable under this Policy for any loss will be paid immediately upon receipt of due written proof of such loss.”
g.) *General Provisions*: Payment of Claims is replaced with the following:
“If the Insured dies, any death benefits or other benefits unpaid at the time of the Insured’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 Insured's:

1. Spouse or Domestic Partner;
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.

If any benefit under this policy is payable to the Insured's estate or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, We may make any payment up to an amount not to exceed $1,000, to any relatives by blood or connection by marriage of the Insured or beneficiary whom We deem to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.
All other benefits due and not assigned will be paid to the Insured, if living.
Otherwise, benefits may, at our option, be paid:

1. according to the beneficiary designation; or
2. to the Insured's estate.

If a benefit due is payable to:

1. the Insured's estate; or
2. the Insured 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 Insured 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 Insured requests otherwise in writing. The Insured must make the request no later than the time he or she files a written proof of loss.
All benefit payments under this Policy will be made in the United States of America in the currency of the United States of America.”
h.) *General Provisions*: Legal Actions is amended to read: “No lawsuit or action in equity can be brought to recover on the Policy before 60 days following the date proof of loss was given to Us. No such action can be brought after expiration of 5 years from the time written proof of loss is required to be furnished.”
i.) *General Provisions*: Subrogation is replaced with the following:
Insurance With Other Insurers
If the Covered Person has other valid coverage with another insurer that provides benefits for the same loss on a provision of service basis or on an expense incurred basis and of which existence We have not been given written notice prior to the occurrence or commencement of loss, Our only liability for any expense incurred coverage under this Policy will be for the proportion of the loss as the amount would otherwise have been payable under this Policy plus the total of the like amounts under all such valid coverages for the same loss of which We had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid that exceed the pro rata portion for the amount so determined.
For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.
j.) *General Provisions*: The following provisions are added:
Time Limit On Certain Defenses: After two years from the date of issue of this Policy no misstatements, except fraudulent misstatement, made by the applicant in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of such two-year period.
No claim for loss incurred commencing after the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss has existed within the 90-day period prior to the effective date of coverage of this Policy.

Cancellation by Insured: The Insured may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon receipt of such notice or on such later date as may be specified in such notice. In the event of cancellation or death of the Insured, We will promptly return the unearned portion of any premium paid. The unearned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

The following is applicable in Louisiana:
a.) *General Provisions*: Subrogation is deleted.
b.) *General Provisions*: The following provisions are added:
Consent of Beneficiary: Consent of the beneficiary shall not be requisite to surrender or assignment of this Policy, nor to change of beneficiary, nor to any other changes in this Policy.
Incontestability: Absent fraud, all statements made by the Insured in the written application or by the Covered Person are deemed representations and not warranties. No such written application made to effectuate insurance 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. In case of death or incapacity of the Covered Person such statement will be furnished to the Covered Person's beneficiary or representative.
c.) *Definitions*: The definition of Dependent is replaced with the following:
"**Dependent**" means an Insured's lawful Spouse or Domestic Partner under age 75; or an Insured's unmarried child, from the moment of birth to age 21, 25 if a full-time student, who is chiefly dependent on the Insured for support. A child, for eligibility purposes, includes an Insured's natural child; adopted child (a child is considered adopted from the moment the Insured is party in a suit to adopt the child); a stepchild who resides with the Insured or depends on the Insured for financial support; or grandchild who is in the legal custody of and residing with the Insured. A full time student is one who is enrolled in and attending an accredited college or university or a vocational, technical, vocational-technical or trade school or institute or secondary school on a full-time basis.
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 MAINLY 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.
If the Insured has elected coverage for a Dependent child, any newly born child of the Insured will be covered from the moment of birth for 31 days. Coverage may be continued beyond this time period if the Insured notifies Us within 31 days of the child's birth and pays any required Premium.

The following is applicable in Maine:
a.) *Definitions*: The definition of Injury is replaced with the following:
"**Injury**" means accidental bodily harm sustained by an Insured that results directly and independently from all other causes from a Covered Accident. All injuries sustained by one person in any one Covered Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.
b.) *Definitions*: The definition of Domestic Partner is replaced with the following:
"**Domestic Partner**" means the partner of an Insured who:

1. Is a mentally competent adult as is the Insured;
2. Has been legally domiciled with the Insured for at least 12 months;
3. Is not legally married to or legally separated from another individual;
4. Is the sole partner of the Insured and expects to remain so; and;
5. Is jointly responsible with the Insured for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property.

The following is applicable in Nevada:
a.) *Definitions*: The definition of Dependent is change to the following:
"**Dependent**" means an Insured's lawful Spouse or Domestic Partner; or an Insured's unmarried child, from the moment of birth to age 19, 25 if a full-time student, 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 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 MAINLY 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.

A CHILD DEPENDENT ON THE OTHER PARENT IS CONSIDERED AN ELIGIBLE DEPENDENT. THE PROPORTION OF THE CHILD'S SUPPORT THAT THE INSURED PROVIDES DOES NOT AFFECT THE CHILD'S ELIGIBILITY FOR COVERAGE.
The Insured will be able to enroll his or her children if required by a court or an administrative order to provide health coverage for such children.
If the Insured has elected coverage for a Dependent child, any newly born child of the Insured will be covered from the moment of birth for 31 days. Coverage may be continued beyond this time period if the Insured notifies Us within 31 days of the child's birth and pays any required Premium.
In the case where the Insured has filed a petition to adopt a child, coverage will begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the child.
b.) *General Provisions*: The following provisions are added:
Medical Transportation: Benefits for medical transportation are payable directly to the provider of the services. This applies only if the provider has not been paid form any other source.]
Claim Denial: If We deny a claim, We will provide a notice of denial within 10 working days of the denial.
c.) *General Provisions*: The Subrogation provision is deleted.

The following is applicable in Oregon:
a.) *Definitions*: The definition of Covered Trip is amended so that the length of the Trip may not exceed 180 days.
b.) *Exclusions*: the following exclusion is amended to read as follows:
3. the Covered Person's commission of war or any act of war, whether declared or not, civil disturbance or insurrection

The following is applicable in South Dakota:
a.) The Excess Insurance Provision is deleted.
b.) *Definitions*: The definition of Dependent is replaced with the following:
"**Dependent**" means an Insured's lawful Spouse or Domestic Partner under age 75; or an Insured's unmarried child, from the moment of birth to age 19, 25 if a full-time student. A child, for eligibility purposes, includes an Insured's

1. natural child without regard to the fact the child:
   a) was born out of wedlock;
   b) is claimed as a dependent on the Insured's federal tax return; and
   c) does not reside with the Insured.
1. adopted child, beginning with any waiting period pending finalization of the child's adoption; or
2. stepchild.

A child dependent on the other parent is considered an eligible Dependent. The proportion of the child's support that the Insured provides does not affect the child's eligibility for coverage.
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. THE CHILD IS NOT CAPABLE OF SELF-SUPPORT; AND
3. THE CHILD DEPENDS MAINLY 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.
c.) *Definitions*: The following is added to the definition of Doctor:
This exclusion does not apply in those areas in which the immediate family member is the only Doctor in the area and acting within the scope of his or her normal employment.
d.) *Definitions*: The definition of Hospital is replaced with the following:
"**Hospital**" means an institution licensed by the South Dakota Department of Health that operates as a Hospital pursuant to law and includes public health centers and general, tuberculosis, mental, chronic disease, and other types of hospitals, and related facilities, including osteopathic hospitals, such as laboratories, out-patient departments, nurses' home and training facilities, and mental service facilities, operated in connection with hospitals, but does not include any hospital furnishing primarily domiciliary care.
e.) *Emergency Accident and Sickness Medical Expense*: The wording "sound natural" that applies to teeth is deleted.
f.) *Exclusions*: The exclusions dealing with intoxication only applies if the Covered Person is committing a felony at the time of loss.

The following is applicable in Washington:
a.) *Definitions*: The definition of Covered Trip is amended to state that the Trip may not exceed a period of 90 days.
b.) *General Provisions*: The following provision is added:
Time Payment Of Claims: Any benefits due will be paid within 30 consecutive days of the date We receive written (or authorized electronic or telephonic) proof of loss.
c.) *General Provisions*: The Legal Actions provision is replaced with the following:
Legal Actions: No lawsuit or action in equity can be brought to recover on the Policy before 12 months from the time when the cause of action accrues.

REFUND POLICY

If for any reason you wish to cancel your policy, you must submit your cancellation request in writing to MEDEX Insurance Services in order to receive a refund of premium. To be eligible for a full refund, the request for cancellation must be received prior to your effective date. Cancellation requests received after the effective date will be subject to the following conditions: 1) only the unused portion of the plan cost will be refunded; and 2) only members who have no claims are eligible for premium refund.

Plan is designed by MEDEX.

This Insurance, under policy #AH-18102 is underwritten by: ACE American Insurance Company at Philadelphia, Pennsylvania.

Policy terms and conditions are briefly outlined in this Description of Coverage. Complete provisions pertaining to this insurance are contained in the Master Policy. In the event of any conflict between this Description of Coverage and the Master Policy, the Master Policy will govern.