## FACTS

### WHAT DOES THE ACE GROUP OF COMPANIES DO WITH YOUR PERSONAL INFORMATION?

<table>
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<tr>
<th>Why?</th>
<th>Insurance companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.</th>
</tr>
</thead>
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<tr>
<td>What?</td>
<td>The types of personal information we collect and share depend on the product or service you have with us. This information can include:</td>
</tr>
<tr>
<td></td>
<td>§ Social Security number and payment history</td>
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<tr>
<td></td>
<td>§ insurance claim history and medical information</td>
</tr>
<tr>
<td></td>
<td>§ account transactions and credit scores</td>
</tr>
<tr>
<td>When you are no longer our customer, we continue to share information about you as described in this notice.</td>
<td></td>
</tr>
<tr>
<td>How?</td>
<td>All insurance companies need to share customers’ personal information to run their everyday business. In the section below, we list the reasons insurance companies can share their customers’ personal information; the reasons the ACE Group chooses to share; and whether you can limit this sharing.</td>
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### Reasons we can share your personal information

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<th>Reasons we can share your personal information</th>
<th>Does ACE share?</th>
<th>Can you limit this sharing?</th>
</tr>
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<td>For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>For our marketing purposes – to offer our products and services to you</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>For joint marketing with other financial companies</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>For our affiliates’ everyday business purposes – information about your transactions and experiences</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>For our affiliates’ everyday business purposes – information about your creditworthiness</td>
<td>No</td>
<td>We don’t share</td>
</tr>
<tr>
<td>For our affiliates to market to you</td>
<td>No</td>
<td>We don’t share</td>
</tr>
<tr>
<td>For nonaffiliates to market to you</td>
<td>No</td>
<td>We don’t share</td>
</tr>
</tbody>
</table>

### Questions?

Call 1-800-352-4462 or go to www.acegroup.com/us-en/contact-us/general-inquiry-form.aspx
## Who we are

| Who is providing this notice? | The ACE Group of Companies. A list of these companies is located at the end of this document. |

## What we do

| How does ACE Group protect my personal information? | To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We restrict access to personal information to our employees, affiliates’ employees, or others who need to know that information to service the account or to conduct our normal business operations. |
| How does ACE Group collect my personal information? | We collect your personal information, for example, when you apply for insurance or pay insurance premiums, file an insurance claim or provide account information, give us your contact information. We also collect your personal information from others, such as credit bureaus, affiliates, or other companies. |

## Why can’t I limit all sharing?

Federal law gives you the right to limit only:

- sharing for affiliates’ everyday business purposes – information about your creditworthiness
- affiliates from using your information to market to you
- sharing for nonaffiliates to market to you

State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.

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## Definitions

| Affiliates | Companies related by common ownership or control. They can be financial and nonfinancial companies. Our affiliates include those with an ACE name and financial companies, such as Westchester Fire Insurance Company and ESIS, Inc. |
| Nonaffiliates | Companies not related by common ownership or control. They can be financial and nonfinancial companies. ACE does not share with nonaffiliates so they can market to you. |
| Joint Marketing | A formal agreement between nonaffiliated financial companies that together market financial products or services to you. Our joint marketing partners include categories of companies such as banks. |
Other important information

For Insurance Customers in CA, CT, GA, IL, MA, ME, MN, MT, NC, NJ, OH, OR, and VA only: Under state law, you have the right to see the personal information about you that we have on file. To see your information, write ACE US Customer Services, P.O. Box 1000, 436 Walnut Street, WA04B, Philadelphia, PA 19106. ACE USA may charge a reasonable fee to cover the costs of providing this information. If you think any of the information is wrong, you may write us. We will let you know what actions we take. If you do not agree with our actions, you may send us a statement. If you want a full description of privacy rights that we will protect in accordance with the law in your home state, please contact us and we will provide it. We may disclose information to certain third parties, such as law enforcement officers, without your permission.

For Nevada residents only: We may contact our existing customers by telephone to offer additional insurance products that we believe may be of interest to you. Under state law, you have the right to opt out of these calls by adding your name to our internal do-not-call list. To opt out of these calls, or for more information about your opt out rights, please contact our customer service department. You can reach us by calling 1-800-352-4462, emailing us at info@acegroup.com, or writing to P.O. Box 1000, 436 Walnut Street, WA04B, Philadelphia, PA 19106. You are being provided this notice under Nevada state law. In addition to contacting ACE, Nevada residents can contact the Nevada Attorney General for more information about your opt out rights by calling 775-684-1100, emailing bcpinfo@ag.state.nv.us, or by writing to: Office of the Attorney General, Nevada Department of Justice, Bureau of Consumer Protection: 100 North Carson Street, Carson City, NV 89701.

For Vermont residents only: Under state law, we will not share information about your creditworthiness within our corporate family except with your authorization or consent, but we may share information about our transactions or experiences with you within our corporate family without your consent.

ACE Group of Companies legal entities

SUMMARY OF GENERAL PURPOSES AND CURRENT LIMITATIONS OF COVERAGE

Residents of the District of Columbia who purchase health insurance, life insurance and annuities should know that the insurance companies licensed in the District of Columbia to write these types of insurance are members of the District of Columbia Life and Health Insurance Guaranty Association (“Guaranty Association”). The purpose of the Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the District of Columbia and, in some cases, to keep coverage in force. The valuable extra protection provided by insurers through the Guaranty Association is limited, however, as noted on the other side of this page.

District of Columbia Life and Health Insurance Guaranty Association Disclaimer

The District of Columbia Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limitations and exclusions. Coverage is generally conditioned on residence in the District of Columbia. Other conditions may also preclude coverage.

The District of Columbia Life and Health Insurance Guaranty Association or the District of Columbia Insurance Commissioner will respond to any questions you may have which are not answered by this document. Your insurer and agents are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy. You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Act of 1992 when selecting an insurer.

Policyholders with additional questions may contact:

Mr. Robert M. Willis
Executive Director
District of Columbia Life and Health Insurance Guaranty Association
1200 G Street, N.W.
Washington, DC 20005
(202) 434-8771
Fax: (202) 347-2990

Mr. William P. White
Commissioner
District of Columbia Department of Insurance, Securities and Banking
810 First Street, N.E., Suite 701
Washington, DC 20002
(202) 727-8000

The District of Columbia law that provides for this safety-net coverage is called the Life and Health Insurance Guaranty Association Act of 1992. The other side of this page contains a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.
**COVERAGE**

Generally, individuals will be protected by the District of Columbia Life and Health Insurance Guaranty Association if they live in the District of Columbia and are insured under a health insurance, life insurance, or annuity contract issued by a member insurer, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**EXCLUSIONS FROM COVERAGE**

However, persons holding such policies are not protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside of that state of incorporation;
- their insurer was not authorized to do business in the District of Columbia; or
- their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance unless an assumption certificate was issued;
- any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
- interest rate guarantees that exceed certain statutory limitations;
- dividends, experience rating credits, or fees for services in connection with a policy;
- credits given in connection with the administration of a policy by a group contract holder; or
- unallocated annuity contracts.

**LIMITS ON AMOUNT OF COVERAGE**

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or,
- with respect to any one life, regardless of the number of policies, contracts, or certificates:
  - $300,000 in life insurance death benefits but not more than $100,000 in net cash surrender or net cash withdrawal values for life insurance; or
  - $100,000 in health insurance benefits, including net cash surrender or net cash withdrawal values; or
  - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values.

Finally, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.
Application is hereby made for a plan of blanket travel Accident and Sickness insurance based on the following statements and representations:

**Applicant (Full Legal Name):** World Learning

- **Street Address:** 1015 15th Street, NW 7th FL
- **City, State, Zip:** Washington, DC 20005

**Policy Number:** GLM N04965619

**Requested Policy Term:** July 1, 2014 to June 30, 2015

**Classes of Eligible Persons:**

- **Class 1:** All active eligible US students of the Policyholder whose names are on file with the Company who are not part of the Swiss University College Program.
- **Class 2:** All active eligible US students of the Policyholder whose names are on file with the Company who are part of the Swiss University College Program.

*Dependents of Class(es) 1, 2 Insureds are eligible for Coverage under the Policy.

**DESCRIPTION OF COVERAGE**

**Covered Activities:**

- **Class 1**
  - Educational Travel
- **Dependents of Class 1**
  - Educational Travel
Class 2  Educational Travel

Dependents of Class 2  Educational Travel

Benefits:
Medical Expense Benefits
Emergency Medical Benefits
Emergency Medical Evacuation Benefit
Repatriation of Remains Benefit

Additional Benefits:
Emergency Reunion Benefit
Home Country Extension Benefit
Lost Baggage Benefit
Personal Property Benefit
Security Evacuation Benefit
Accidental Death & Dismemberment

Premiums:
Class 1: $78.71 per student per month
       $143.78 per Dependent per month

Class 2: $90.51 per student per month
       $165.35 per Dependent per month

The Applicant represents the information contained in this Application is true and correct and forms the basis of the requested insurance.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

______________________________
Signed for the Policyholder

______________________________
Title

______________________________
Date
Signed by Licensed Resident Agent
(Where Required by Law)
POLICYHOLDER: World Learning
POLICY NUMBER: GLM N04965619
POLICY EFFECTIVE DATE: July 1, 2014
POLICY TERM: July 1, 2014 to June 30, 2015

This Policy takes effect at 12:00 a.m. (midnight) at the Policyholder’s address on the Policy Effective Date shown above. It will remain in effect for the duration of the Policy Term shown above if the premium is paid according to the agreed terms. This Policy terminates at 12:00 a.m. (midnight) at the Policyholder’s address, on the last day of the Policy Term unless the Policyholder and We agree to continue coverage under this Policy for an additional Policy Term. If coverage is continued for an additional Policy Term and the required premiums are paid on or before the Premium Due Date, We will issue an amendment to identify the new Policy Term.

This Policy is governed by the laws of the state in which it is delivered.


JOHN J. LUPICA, President

THREE FCIC L. COLLINS, Secretary

THIS POLICY PROVIDES COVERAGE THAT IS SUPPLEMENTAL TO A DOMESTIC GROUP HEALTH PLAN. IT IS NOT A MAJOR MEDICAL OR COMPREHENSIVE MEDICAL POLICY. IT PAYS OUT-OF-COUNTRY MEDICAL EXPENSE BENEFITS ONLY. PLEASE READ THE POLICY CAREFULLY.
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SCHEDULE OF BENEFITS

PREMIUM DUE DATE: On or before the Policy Effective Date.

CLASSES OF ELIGIBLE PERSONS:

A person may be insured only under one Class of Eligible Persons even though he or she may be eligible under more than one class. Also, a person may not be insured as a Dependent and an Insured at the same time.

Class 1 All active eligible US students of the Policyholder whose names are on file with the Company who are not part of the Swiss University College Program.
Class 2 All active eligible US students of the Policyholder whose names are on file with the Company who are part of the Swiss University College Program.

*Dependents of Class(es) 1, 2 Insureds are eligible for Coverage under this Policy.

COVERED ACTIVITIES:

Class 1 Educational Travel
Dependents of Class 1 Educational Travel
Class 2 Educational Travel
Dependents of Class 2 Educational Travel

BENEFITS:

Medical Expense Benefits
Total Maximum for all Accident or Sickness Expense Benefits:
Class 1: $100,000
Class 2 $500,000
Spouse of Class 1 $100,000
Spouse of Class 2 $500,000
Children of Class 1 $100,000
Children of Class 2 $500,000

Maximum for Preexisting Conditions: treated as any other medical condition

Maximum for Dental Treatment
(Injury Only): $1,000, subject to $100 per tooth

Maximum for Emergency Medical Treatment of Pregnancy: treated as any other medical condition

Maximum for Room & Board Charges: the average semi-private room rate

Maximum for ICU Room & Board Charges: two times the average semi-private room rate

Maximum for Chiropractic Care: $500

Maximum for Mental and Nervous Disorders: $20,000

Maximum for Prescription Drugs:
   Inpatient: Brand Name Drugs: $3,000
   Generic Drugs: $3,000
   Outpatient: Brand Name Drugs: $1,000
   Generic Drugs: $3,000

Benefits include expenses for immunizations received due to a quarantine occurring during the Trip.

Deductible: $50 per Covered Accident or Sickness

Co-insurance Rate: 100% of the Usual and Customary Charges

Incurral Period: 30 days after the date of Covered Accident or Sickness

Maximum Benefit Period: The earlier of the date the Covered Person’s Trip ends, or 364 days from the date of a Covered Accident or Sickness

Maximum Period of Coverage: 180 days

Emergency Medical Benefits
   Benefit Maximum: up to $10,000

Emergency Medical Evacuation Benefit
   Benefit Maximum: 100% of the Covered Expenses

Repatriation of Remains Benefit
   Benefit Maximum: 100% of the Covered Expenses

Emergency Reunion Benefit
   Benefit Maximum: $10,000
   Daily Benefit Maximum: $2,000
Maximum Number of Days: 5

Benefit Maximum for Repatriation of Remains: $5,000

**Home Country Extension Benefit**
Benefit Maximum: up to the Medical Expense Benefit Maximum
Deductible: $0
Maximum Benefit Period: 30 days

**Lost Baggage Benefit**
Deductible per Trip: $25
Benefit Maximum per Trip: $1,000
Benefit Maximum per Item or Set of Items: $250 subject to a Maximum of 2 bags

**Personal Property Benefit**
Deductible per Trip: $25
Benefit Maximum per Trip: $5,000
Benefit Maximum per Item or Set of Items: $5,000

**Security Evacuation Expense Benefit**
Benefit Maximum: $10,000
Aggregate Limit per Occurrence: $250,000

**AGGREGATE LIMIT:**
Benefit Maximum: $750,000

We will not pay more than the Benefit Maximum for all losses per Covered Accident. If, in the absence of this provision, We would pay more than Benefit Maximum for all losses from one Covered Accident, then the benefits payable to each person with a valid claim will be reduced proportionately, so the total amount We will pay is the Benefit Maximum.

**Accidental Death & Dismemberment Benefits**
Principal Sum:
- Class 1: $5,000
- Class 2: $5,000
- Spouse of Class 1: $5,000
- Spouse of Class 2: $5,000
Children of Class 1  $5,000
Children of Class 2  $5,000

INITIAL PREMIUM RATES:
Class 1: $78.71 per student per month
        $143.78 per Dependent per month

Class 2: $90.51 per student per month
        $165.35 per Dependent per month
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.

“Active Service” means a Covered Person is either 1) actively at work performing all regular duties at his or her employer’s place of business or someplace the employer requires him or her to be; 2) employed, but on a scheduled holiday, vacation day, or period of approved paid leave of absence; or 3) if not employed, able to engage in substantially all of the usual activities of a person in good health of like age and sex and not confined in a Hospital or rehabilitation or rest facility.

“Country of Permanent Assignment” means a country, other than a Covered Person’s Home Country, in which the Policyholder requires a Covered Person to work for a period of time that exceeds 180 continuous days.

“Country of Permanent Residence” means a country or location in which the Covered Person maintains a primary permanent residence.

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

“Covered Activity” means any activity in which a Covered Person must be engaged when a Covered Accident occurs in order to be eligible for benefits under the Policy. These Covered Activities are listed in the Schedule of Benefits and described in the Hazards section of the Policy.

“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 Policyholder’s Policy must remain continuously in force from the date of the Covered 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 eligible person, including Dependents if eligible for coverage under the Policy, for whom the required premium is paid. If the cost for this insurance is paid for by the Policyholder, individual applications are not required for an eligible person to be a Covered Person.

“Deductible” means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person per Covered Accident or Sickness basis before Medical Expense Benefits and/or other Additional Benefits paid on an expense incurred basis are payable under the Policy.

“Dependent” means an Insured’s lawful spouse under age 70 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.

“Dependent” also means an Insured’s Domestic Partner. “Domestic Partner” means a person of the same or opposite sex of the Insured who:

1) shares the Insured’s primary residence;
2) has resided with the Insured for at least 12 months prior to the date of enrollment and is expected to reside with the Insured indefinitely;
3) is financially interdependent with the Insured 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 Insured, if recognized by the laws of the state in which he or she resides with the Insured;
5) has not signed a Domestic Partner declaration with any other person within the last 12 months.
6) is 18 years of age or older;
7) is not currently married to another person;
8) is not in a position as a blood relative that would prohibit marriage.

“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.

“Home Country” means a country from which the Covered Person holds a passport. If the Covered Person holds passports from more than one Country, his or her Home Country will be the country that he or she has declared to Us in writing as his or her Home Country. Home Country also includes the Covered Person’s Country of Permanent Assignment or Country of Permanent Residence.

“Hospital” means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment, and providing of inpatient 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) provides organized facilities for diagnosis, treatment, and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a prearranged 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.

“Insured” means a person in a Class of Eligible Persons for whom the required premium is paid making insurance in effect for that person.

“Medical Emergency” means a condition caused by an Injury or Sickness that manifests itself by symptoms of sufficient severity that a prudent lay person 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; 2) 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) eyeglass 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.

“Preexisting Condition” means an illness, disease, or other condition of the Covered Person that in the 3 months period before the Covered Person’s coverage became effective under the Policy:
1. first manifested itself, worsened, became acute, or exhibited symptoms that would have caused a 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.

“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 this Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

“Trip” means Policyholder sponsored travel by air, land, or sea from the Covered Person’s Home Country. It includes the period of time from the start of the trip until its end provided the Covered Person is engaged in a Covered Activity or Personal Deviation if covered under the Policy.

“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 insurance company underwriting this insurance or its authorized agent.
ELIGIBILITY FOR INSURANCE

Each person in one of the Classes of Eligible Persons shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date, or the day he or she becomes eligible, if later. We maintain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

An Insured’s Dependent is eligible on the date:
1. the Insured is eligible, if the Insured has Dependents on that date; or
2. the date the person becomes a Dependent, if later.

In no event will a Dependent be eligible if the Insured is not eligible.

EFFECTIVE DATE OF INSURANCE

An Eligible Person will be insured on the later of Policy Effective Date or the date he or she is eligible, if not required to contribute to the cost of this insurance.

If an Eligible Person or Dependent is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to Active Service. A Dependent’s insurance will not be in effect prior to the date an Eligible Person is insured.

TERM OF COVERAGE

This coverage will start on the actual start of the Trip. It does not matter whether the Trip starts at the Covered Person’s home, place of work, or other place. It will end on the first of the following dates to occur:
1. the date the Covered Person returns to his or her Home Country;
2. the scheduled Trip return date; or
3. the date the Covered Person makes a Personal Deviation (unless otherwise provided by the Policy).

“Personal Deviation” means:
1. An activity that is not reasonably related to the Covered Activity; and
2. Not incidental to the purpose of the Trip.

TERMINATION DATE OF INSURANCE

An Insured’s coverage will end on the earliest of the date:
1. the Policy terminates;
2. the Insured is no longer eligible; or
3. the period ends for which premium is paid.

A Dependent’s coverage will end on the earliest of the date:
1. he or she is no longer a Dependent;
2. the Insured’s coverage ends; or
3. the period ends for which premium is paid.

Termination of the Policy will not affect Trip coverage, if premium for the Trip is paid prior to the actual start of the Trip.
SCOPE OF COVERAGE

Primary Excess Benefits

We will pay the first $2,000 of Covered Medical Expenses shown in the Schedule of Benefits without regard to any other Health Care Plan benefits payable for the Covered Person. We will then pay expenses:
1. after the Covered Person satisfies any Deductible; and
2. only when they are in excess of any amounts payable by any other Health Care Plan.

We pay benefits without regard to any Coordination of Benefits provisions in any other Health Care Plan.

“Health Care Plan” means a policy or other benefit or service arrangement for medical or dental care or treatment under: 1) group or blanket coverage, whether on an insured or self-funded basis; 2) hospital or medical service organizations on a group basis; 3) Health Maintenance Organizations on a group basis; 4) group labor-management plans; 5) employee benefit organization plans; 6) association plans on a group or franchise basis; or 7) any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended.

DESCRIPTION OF BENEFITS

The following Provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits on a class level.

Medical Expense Benefits

We 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 Deductible, Co-insurance Rate, Maximum Benefit Period, Benefit Maximum, and other terms or limits shown in the Schedule of Benefits.

Medical Expense Benefits are only payable:
1. for Usual and Customary Charges incurred after the Deductible, if any, has been met;
2. for those Medically Necessary Covered Expenses that the Covered Person incurs;
3. for charges incurred for services rendered to the Covered Person while on a covered Trip; and
4. provided the first charge is incurred within the Incurral Period shown in the Schedule of Benefits.

Covered Medical Expenses

- Hospital semi-private room and board (or room and board in an intensive care unit);
- Hospital ancillary services (including, but not limited to, use of the operating room or emergency room)
- Services of a Doctor or a registered nurse (R.N.)
- Ambulance service to or from a Hospital
• Laboratory tests
• Radiological procedures
• Anesthetics and their administration
• Blood, blood products, artificial blood products, and the transfusion thereof
• Physiotherapy
• Chiropractic expenses on an inpatient or outpatient basis
• Medicines or drugs administered by a Doctor or that can be obtained only with a Doctor’s written prescription
• Dental charges for Injury to sound, natural teeth
• Emergency medical treatment of pregnancy
• Therapeutic termination of pregnancy
• Artificial limbs or eyes (not including replacement of these items)
• Casts, splints, trusses, crutches, and braces (not including replacement of these items or dental braces)
• Oxygen or rental equipment for administration of oxygen
• Rental of a wheelchair or hospital-type bed
• Rental of mechanical equipment for treatment of respiratory paralysis
• Mental and Nervous Disorders: limited to one treatment per day. "Mental and Nervous Disorders" means neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind
• Pregnancy and childbirth

Emergency Medical Benefits

We will pay Emergency Medical Benefits as shown in the Schedule of Benefits for Covered Expenses incurred for emergency medical services to treat a Covered Person. Benefits are payable up to the Benefit Maximum shown in the Schedule of Benefits if the Covered Person:
1. suffers a Medical Emergency during the course of the Trip; and
2. is traveling on a covered Trip.

Covered Expenses:
1. Medical Expense Guarantee: expenses for guarantee of payment to a medical provider.
2. Hospital Admission Guarantee: expenses for guarantee of payment to a Hospital or treatment facility.

Benefits for these Covered Expenses will not be payable unless:
1. the charges incurred are Medically Necessary and do not exceed the charges for similar treatment, services, or supplies in the locality where the expense is incurred; and
2. do not include charges that would not have been made if there were no insurance.

Benefits will not be payable unless We (or Our authorized assistance provider) authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our assistance provider.

Emergency Medical Evacuation Benefit

We 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 Benefit Maximum shown in the Schedule of Benefits, if the Covered Person:
1. suffers a Medical Emergency during the course of the Trip;
2. requires Emergency Medical Evacuation; and
3. is traveling on a covered Trip.

Covered Expenses:
1. Medical Transport: expenses for transportation under medical supervision to a different hospital, treatment facility or to the Covered Person’s place of residence for Medically Necessary treatment in the event of the Covered Person’s Medical Emergency and upon the request of the Doctor designated by Our assistance provider 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 Our service provider 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 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.
4. Escort Services: expenses for an Immediate Family Member or companion who is traveling with the Covered Person to join the Covered Person during the Covered Person’s emergency medical evacuation to a different hospital, treatment facility, or the Covered Person’s place of residence.

“Immediate Family Member” means a Covered Person’s spouse, child, brother, sister, parent, grandparent, or in-law.

Benefits for these Covered Expenses will not be payable unless:
1. the Doctor ordering the Emergency Medical Evacuation certifies the severity of the Covered Person’s Medical Emergency requires an Emergency Medical Evacuation;
2. all transportation arrangements made for the Emergency Medical Evacuation are by the most direct and economical conveyance and route possible;
3. the charges incurred are Medically Necessary and do not exceed the charges for similar transportation, treatment, services, or supplies in the locality where the expense is incurred; and
4. do not include charges that would not have been made if there were no insurance.

Benefits will not be payable unless We (or Our authorized assistance provider) authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our assistance provider. In the event the Covered Person refuses to be medically evacuated, we will not be liable for any medical expenses incurred after the date medical evacuation is recommended.

Repatriation of Remains Benefit

We 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 on a covered Trip. Covered expenses include:
1. expenses for embalming or cremation;
2. the least costly coffin or receptacle adequate for transporting the remains;
3. transporting the remains;
4. Escort Services: expenses for an Immediate Family Member or companion who is traveling with the Covered Person to join the Covered Person's body during the repatriation to the Covered Person's place of residence.

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 (or Our authorized assistance provider) authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our assistance provider.

Emergency Reunion Benefit

We will pay up to the Benefit Maximum as shown in the Schedule of Benefits for expenses incurred to have a Covered Person's Family Member accompany him or her to the Covered Person's Home Country or the Hospital where the Covered Person is confined if the Covered Person is: 1) confined in a Hospital for at least 24 consecutive hours due to a covered Injury or Sickness and the attending Doctor believes it would be beneficial for the Covered Person to have an Family Member at his or her side; or 2) the victim of a Felonious Assault. The Family Member’s travel must take place within 7 days of the date the Covered Person is confined in the Hospital, or the date of the occurrence of the Felonious Assault.

“Felonious Assault” means a violent or criminal act reported to the local authorities which was directed at the Covered Person during the course of, or an attempt of, a physical assault resulting in serious injury, kidnapping, or rape.

Covered expenses include an economy airline ticket and other travel related expenses not to exceed the Daily Benefit Maximum and the Maximum Number of Days shown in the Schedule of Benefits.

All transportation and lodging arrangements must be made by the most direct and economical route and conveyance possible and may not exceed the usual level of charges for similar transportation or lodging in the locality where the expense is incurred. Benefits will not be payable unless We (or Our authorized assistance provider) authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our assistance provider.

“Family Member” means a Covered Person’s parent, sister, brother, husband, wife, child, grandparent, or immediate in-law.

Home Country Extension Benefit

We will pay benefits for Covered Medical Expenses up to the Benefit Maximum shown in the Schedule of Benefits if the Covered Person obtains treatment of a covered Injury or Sickness while he or she is in his or her Home Country provided treatment is rendered within the Incurable Period shown in the Schedule of Benefits. These benefits are limited to the benefits that would be otherwise payable under the Medical Expense Benefit if the Covered Person were outside of his or her Home Country. Benefits are payable under the Policy only to the extent that Covered Expenses are not payable under any other domestic health care plan.
Coverage under this benefit begins on the date the Covered Person arrives in his or her Home Country. It ends the later of: 1) the Maximum Benefit Period shown in the Schedule of Benefits, or 2) the date the Covered Person leaves his or her Home Country. This benefit is payable only once in any 12-month period.

Home Country Extension Benefit payments are subject to the Deductible, Coinsurance Rate, and Benefit Maximum shown in the Schedule of Benefits for Medical Expense Benefits.

**Lost Baggage Benefit**

We will reimburse the Covered Person’s replacement costs of clothes and personal hygiene items, up to the Benefit Maximum shown in the Schedule of Benefits, if the Covered Person’s luggage is checked onto a common carrier, and is then lost, stolen, or damaged beyond his or her use. Replacement costs are calculated on the basis of the depreciated standard for the specific personal item claimed and its average usable period. The Covered Person must file a formal claim with the transportation provider and provide Us with copies of all claim forms and proof that the transportation provider has paid the Covered Person its normal reimbursement for the lost, stolen, or damaged luggage.

**Personal Property Benefit**

We will reimburse the Covered Person the reasonable cost, up to the Benefit Maximum shown in the Schedule of Benefits after satisfaction of the Deductible, for replacement of any personal property that is lost or totally destroyed while the Covered Person is on his or her Trip. Replacement costs are calculated on the basis of the depreciated standard for the specific personal item claimed and its average usable period. The Covered Person must demonstrate that he or she has taken reasonable precautions for the safety and security of any covered property, and We require certification by a police or security authority in an incident report.

For any claim the Covered Person makes under this Benefit, We are entitled to make reasonable repairs or salvage efforts to restore his or her personal property or to keep the damaged property if We choose to do so. We will require valid receipts of replacement goods prior to payment of any benefits.

“Personal Property” means personal goods belonging to the Insured or for which the Insured is responsible and are taken on the business Trip or acquired by the Insured during the Trip. It does not include vehicles (including aircraft and other conveyances) or their accessories or equipment or laptops.

**Security Evacuation Expense Benefit**

We will pay Security Evacuation Expense Benefits to the Covered Person, if:

1. an Occurrence takes place during the Covered Activity described in the Policy and his or her Term of Coverage; and
2. while he or she is traveling outside of his or her Home Country.

Benefits will be subject to the Benefit Maximum shown in the Schedule of Benefits.

Benefits will be paid for:
1. the Covered Person’s Transportation and Related Costs to the Nearest Place of Safety necessary to ensure his or her safety and well-being as determined by the Designated Security Consultant.

2. the Covered Person’s Transportation within 5 days of the Security Evacuation to either of the following locations as chosen by the Covered Person:
   a. back to the country in which the Covered Person is traveling during the Covered Activity but only if 1) coverage remains in force under the Policy; and 2) there is no U.S. State Department Travel Warning in place on the date the Covered Person is scheduled to return; or
   b. the Covered Person’s Home Country; or
   c. where the Policyholder that sponsored the Covered Person’s Trip is located.

3. consulting services by a Designated Security Consultant for seeking information on a Missing Person or kidnapping case, if the Covered Person is considered kidnapped or a Missing Person by local or international authorities.

Security Evacuation Expense Benefits are payable only once for a Covered Person for any one Occurrence.

Benefits will not be payable unless We (or Our authorized assistance provider) authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our assistance provider. Our assistance provider is not responsible for the availability of Transport services. Where a Security Evacuation becomes impractical due to hostile or dangerous conditions, a Designated Security Consultant will endeavor to maintain contact with the Covered Person until a Security Evacuation occurs.

Right of Recovery - If, after a Security Evacuation is completed, it becomes evident that the Covered Person was an active participant in the events that led to the Occurrence, We have the right to recover all Transportation and Related Costs from the Covered Person.

Changes in Terms and Conditions - The terms and conditions of this benefit may be changed at any time to reflect conditions that, in Our opinion, constitute a change in the Policyholder’s Security Evacuation exposure. We will give at least 31 days advance written notice (or authorized electronic or telephonic means) to the Policyholder of any change in the terms and condition of this benefit.

“Appropriate Authority(ies)” means the U.S. State Department, the government authority(ies) in the Covered Person’s Home Country or Country of Residence or the government authority(ies) of the Host Country.

“Designated Security Consultant” means an employee of a security firm under contract with Us or Our assistance provider who is experienced in security and measures necessary to ensure the safety of the Covered Person(s) in his or her care.

“Evacuation Advisory” means a formal recommendation issued by the Appropriate Authority(ies) that the Covered Person or citizens of his or her Home Country or Country of Residence or citizens of the Host Country leave the Host Country.

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

Natural disaster does not mean nuclear reactions, uninhabitable property, transportation strikes, lost or stolen passport or travel documents, radiation or radioactive contamination, civil disorder and other similar events.

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

“Occurrence” means any of the following situations involving a Covered Person that trigger the need for a Security Evacuation:
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 Authority(ies) issue an advisory stating that citizens of the Covered Person’s Home Country or Country of Residence or citizens of the Host Country should leave the Host Country;
3. Natural Disaster within seven (7) days of an event;
4. 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;
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.

“Related Costs” means lodging and, if necessary, physical protection for the Covered Person during or while waiting for Transport to the Nearest Place of Safety. Related Costs will include temporary lodging, if necessary, while a Covered Person is waiting to be transported back to the Host Country, Home Country or other country where the Policyholder that sponsored the Covered Person’s Trip is located. Benefits will not be payable for Related Costs unless We (or Our authorized assistance provider) authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our assistance provider.

“Security 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.

“Transport” or “Transportation” means the most efficient and available method of conveyance, where practical, economy fare will be utilized. If possible, the Covered Person’s common carrier tickets will be used.
Additional Exclusions - We will not pay Security Evacuation Expense Benefits for expenses and fees:
1. payable under any other provision of the Policy.
2. that are recoverable through the Covered Person’s employer or other entity sponsoring
the Covered Person’s Trip.
3. arising from or attributable to an actual fraudulent, dishonest or criminal act committed or
attempted by the Covered Person, acting alone or in collusion with other persons.
4. arising from or attributable to an alleged:
   a. violation of the laws of the country in which the Covered Person is traveling while
      covered under the Policy; or
   b. violation of the laws of the Covered Person’s Home Country or Country of
      Residence.
5. due to the Covered Person’s failure to maintain and possess duly authorized and issued
required travel documents and visas.
6. for repatriation of remains expenses.
7. for common or endemic or epidemic diseases or global pandemic disease as defined by
the World Health Organization.
8. for medical services.
9. for monies payable in the form of a ransom, if a Missing Person case evolves into a
kidnapping.
10. arising from or attributable, in whole or in part, to:
    a. a debt, insolvency, commercial failure, the repossession of any property by any
       title holder or lien holder or any other financial cause;
    b. non-compliance by the Covered Person with regard to any obligation specified in
       a contract or license.
11. due to military or political issues if the Covered Person’s Security Evacuation request is
    made more than 10 days after the Appropriate Authority(ies) Advisory was issued.
12. failure of a Covered Person to cooperate with Us or Our assistance provider with regard
to a Security Evacuation. Such cooperation includes, but is not limited to, failure to
provide any documents needed to extricate the Covered Person, failure to follow the
directions given by Our designated security consultants during a Security Evacuation.

If a Covered Person refuses to participate in a Security Evacuation, or any part of a Security
Evacuation, no further benefits will be payable under the Security Evacuation Expense Benefit
for that Occurrence.

Accidental Death and Dismemberment Benefits

If Injury to the Covered Person results in any one of the losses shown below within 365 days
from the date of a Covered Accident, We will pay the Benefit Amount shown below for that loss.
The Principal Sum is shown in the Schedule of Benefits. If multiple losses occur, only one
Benefit Amount, the largest, will be paid for all losses due to the same Covered Accident.

Schedule of Covered Losses

<table>
<thead>
<tr>
<th>Covered Loss</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100% of the Principal Sum</td>
</tr>
<tr>
<td>Two or more Members</td>
<td>100% of the Principal Sum</td>
</tr>
<tr>
<td>Quadruplegia</td>
<td>100% of the Principal Sum</td>
</tr>
<tr>
<td>Loss of Use of Four Limbs</td>
<td>100% of the Principal Sum</td>
</tr>
</tbody>
</table>

AH-15090 ACE American Insurance Company 19
Loss of Use of Three Limbs ................................................................. 75% of the Principal Sum
Loss of Use of Two Limbs ............................................................... 67% of the Principal Sum
One Member .................................................................................. 50% of the Principal Sum
Hemiplegia ....................................................................................... 50% of the Principal Sum
Paraplegia ......................................................................................... 50% of the Principal Sum
Loss of Use of One Limb ................................................................. 50% of the Principal Sum
Thumb and Index Finger of the Same Hand ................................. 25% of the Principal Sum
Uniplegia .......................................................................................... 25% of the Principal Sum

“Quadriplegia” means total Paralysis of both upper and lower limbs. “Hemiplegia” means total Paralysis of the upper and lower limbs on one side of the body. “Uniplegia” means total Paralysis of one lower limb or one upper limb. “Paraplegia” means total Paralysis of both lower limbs or both upper limbs. “Paralysis” means total loss of use. A Doctor must determine the loss of use to be complete and not reversible at the time the claim is submitted.

“Member” means Loss of Hand or Foot and Loss of Sight. “Loss of Hand or Foot” means complete Severance through or above the wrist or ankle joint. “Loss of Sight” means the total, permanent Loss of Sight of one eye. “Loss of a Thumb and Index Finger of the Same Hand” means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). “Severance” means the complete separation and dismemberment of the part from the body.

“Loss of Use” means total paralysis of a limb or limbs which is determined by a competent medical authority to be permanent, complete and irreversible with respect to: 1) arm, at or above the elbow joint; 2) leg, at or above the knee joint; 3) hand, at or above the wrist joint; and, 4) foot, at or above the ankle joint.

HAZARDS INSURED AGAINST

We will pay benefits described in this Policy when a Covered Person suffers a loss or Injury as a result of a Covered Accident or Sickness during one of the Covered Activities listed in the Schedule of Benefits. We will only pay benefits if the Insured is engaged in one of the hazards described below when the Covered Accident occurs. Unless otherwise specified, We pay benefits only once for any one Covered Accident or Sickness, even if it is covered by more than one hazard.

Educational Travel

We will pay the benefits described in this Policy only if a Covered Person suffers a loss or incurs a Covered Expense as the direct result of a Covered Accident or Sickness while traveling:
1. outside of his or her Home Country;
2. up to the Maximum Period of Coverage shown in the Schedule of Benefits under the Medical Expense Benefit; and
3. engaging in educational activities sponsored by the Policyholder.

Exposure & Disappearance

Coverage under this hazard includes exposure to the elements after the forced landing, stranding, sinking, or wrecking of a vehicle in which the Covered Person was traveling.
A Covered Person is presumed dead if:
1. he or she is in a vehicle that disappears, sinks, or is stranded or wrecked on a trip covered by this Policy; and
2. the body is not found within one year of the Covered Accident.

EXCLUSIONS AND LIMITATIONS

We will not pay benefits for any loss or Injury that is caused by or results from:
• intentionally self-inflicted injury; suicide or attempted suicide.
• war or any act of war, whether declared or not.
• a Covered Accident that occurs while a Covered Person is on active duty service in the military, naval or air force of any country or international organization. Upon receipt of proof of service, we will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
• piloting or serving as a crewmember in any aircraft (unless otherwise provided in the Policy).
• commission of, or attempt to commit, a felony.
• sickness, disease, bodily or mental infirmity, bacterial or viral infection, or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food (Applicable to accident benefits only).
• the Covered Person being legally intoxicated as determined according to the laws of the jurisdiction in which the Injury occurred.

In addition, We will not pay Medical Expense Benefits for any loss, treatment, or services resulting from:
• routine physicals and care of any kind.
• routine dental care and treatment.
• routine nursery care.
• cosmetic surgery, except for reconstructive surgery needed as the result of an Injury.
• eye refractions or eye examinations for the purpose of prescribing corrective lenses or for the fitting thereof; eyeglasses, contact lenses, and hearing aids.
• services, supplies, or treatment including any period of Hospital confinement which is not recommended, approved, and certified as Medically Necessary and reasonable by a Doctor, or expenses which are non-medical in nature.
• treatment or service provided by a private duty nurse.
• treatment by any Immediate Family Member or member of the Insured’s household. “Immediate Family Member” means a Covered Person’s spouse, child, brother, sister, parent, grandparent, or in-laws.
• expenses incurred during travel for purposes of seeking medical care or treatment, or for any other travel that is not in the course of the Policyholder’s activity (unless Personal Deviations are specifically covered).
• medical expenses for which the Covered Person would not be responsible to pay for in the absence of the Policy. Expenses incurred for services provided by any government Hospital or agency, or government sponsored-plan for which, and to the extent that, the Covered Person is eligible for reimbursement.
In addition to the Policy Exclusions, We will not pay Lost Baggage, Personal Property, Benefit(s) for:

- loss or damage due to:
  - moth, vermin, insects, or other animals; wear and tear; atmospheric or climatic conditions; or gradual deterioration or defective materials or craftsmanship;
  - mechanical or electrical failure;
  - any process of cleaning, restoring, repairing, or alteration.
- more than a reasonable proportion of the total value of the set where the loss or damaged article is part of a set or pair.
- devaluation of currency or shortages due to errors or omissions during monetary transactions.
- any loss not reported to either the police or transport carrier within 24 hours of discovery.
- any loss due to confiscation or detention by customs or any other authority.

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 Insured is eligible for reimbursement.

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

**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.

**Claim Forms:** Upon receiving written notice of claim, We will send 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.

**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.

**Claimant Cooperation Provision:** Failure of a claimant to cooperate with Us in the administration of a claim may result in the 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:** Any benefits due will be paid when We receive written (or authorized electronic or telephonic) proof of loss.

**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.

If a Covered Loss is suffered by a Covered Person who resides outside of the United States, its territories and possessions and in a Country where the Company is not permitted to provide insurance without a License, the Company will pay benefits under the Policy to the Policyholder, who:

1. will hold such payment in trust for the sole use and benefit of the insured person or his or her beneficiary or other person to whom such benefits are payable (“Payee”); and
2. will remit such payment to the Payee in accordance with applicable law.

Any such payment the Company makes to the Policyholder is a full discharge of the Company’s liability for the claim for which payment is made.

“Country” includes any political jurisdiction that independently regulates the licensing of insurance companies.

“License” or “Licensed” means with respect to any Country, authorized or otherwise permitted in accordance with applicable law to conduct the business of accident and sickness insurance in such Country.
Beneficiary: The Insured may designate a beneficiary for Accidental Death Benefits, if any. 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: We may pay benefits directly to any Hospital or person rendering covered services, unless the Covered Person requests otherwise in writing no later than the time he or she submits written proof of loss. 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 this 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.

ADMINISTRATIVE PROVISIONS

Premiums: The premiums for this Policy will be based on the rates currently in force, the plan and amount of insurance in effect.

Changes In Premium Rates: We may change the premium rates from time to time with at least 31 days advanced written, or authorized electronic or telephonic notice. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period. However, We reserve the right to change rates at any time if any of the following events take place.
1. The terms of the Policy change.
2. A division, subsidiary, affiliated organization, or eligible class is added or deleted from the Policy.
3. Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.
4. There is a change in the market factors or factors bearing on the risk assumed.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Payment of Premium: The first Premium is due on the Policy Effective Date. If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period: A Policy Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required
premiums are not paid during the Policy Grace Period, insurance will end on the last Premium Due Date on which required premiums were paid. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

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 shown on page 1 of the Policy. We may terminate this Policy by giving 31 days advance notice in writing (or authorized electronic or telephonic means) to the Policyholder. The Policyholder may terminate this Policy on any Premium Due Date by giving 31 days advance written (or authorized electronic or telephonic) notice to 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.

Certificates Of Insurance: Where it is required by law, or upon the request of the Policyholder, We will make available certificates outlining the insurance coverage and to whom benefits are payable under the Policy.

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.

Not In Lieu Of Workers’ Compensation: This Policy is not a workers’ compensation policy. It does not provide workers’ compensation benefits.
This policy provides travel insurance benefits for individuals traveling outside of their home country. This policy does not constitute comprehensive health insurance coverage (often referred to as “major medical coverage”) and does not satisfy a person’s individual obligation to secure the requirement of minimum essential coverage under the Affordable Care Act (ACA).

For more information about the ACA, please refer to www.HealthCare.gov.