SHORT TERM TRAVEL INSURANCE

Description of Coverage

This Description of Coverage provides a summary of the important features of the coverage. This is part of the insurance contract. This insurance is provided to Eligible Classes of persons of the Policyholder while those persons are on Covered Trips as defined hereafter.

ELIGIBLE CLASS(ES) FOR COVERAGE

The persons eligible for coverage are:

III All registered Student participants who are non US citizens or residents engaged in education while visiting the USA then while traveling outside of their home country and whose name is on file and for whom appropriate premium has been paid.

SCHEDULE OF BENEFITS

Baggage and Personal Effects Benefit
Personal Effects Replacement Maximum ................................................................. $1,000
Checked Baggage Delivery Charge Maximum ......................................................... $100
Lost Checked Baggage/Personal Effects Maximum ................................................ $2,500
   Per Article Maximum ........................................................................................... $1,000
   Combined Maximum Limit .................................................................................... $500

Security Evacuation Benefit
Maximum Security Evacuation Benefit ................................................................. $25,000

Quarantine Benefit
Per Day Quarantine Benefit ................................................................................... $100
Maximum Trip Quarantine Benefit ......................................................................... $1,000

Principal Sum Benefits
Principal Sum ........................................................................................................... $10,000
Aggregate Limit ....................................................................................................... $750,000

Medical Expense Benefit
Medical Expense Maximum Benefit ......................................................................... $100,000
Percentage Payable ................................................................................................ 100%
Plan Deductible ....................................................................................................... None

Home Country Maximum
   Limited Applicability – See page 13 ................................................................ $25,000

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(P&C/A&H)
Medical Expense Limitations

- Hospital charges in excess of the Hospital’s average daily charge for semi-private room and board accommodation are not covered.

- Charges for medication on an outpatient basis requiring a written prescription by a Physician are covered up to a maximum of $1,000 per covered Injury or Sickness.

- Charges for physical therapy are covered up to a maximum benefit of $50 per visit for up to 10 visits.

- Charges for chiropractic care are covered up to a maximum of $50 per visit and for up to 10 visits.

- Charges for dental treatment of Injury to sound natural teeth are covered up to a maximum of $100 per tooth and an overall maximum of $1,000 per Injury.

- Charges for emergency palliative dental treatment to natural teeth to relieve dental pain is covered up to a maximum of $500.

Maximum Medical Emergency Guarantee Charge Expense Benefit............................ $10,000.

Repatriation of Remains Benefit

Maximum Repatriation of Remains Benefit................................................................. $100,000

Attendor Benefit

Per Day Allotments
- for lodging .................................................................................................................. $100
- for meals ..................................................................................................................... $50

Bedside Benefit

Per Day Allotments
- for lodging .................................................................................................................. $400
- for meals ..................................................................................................................... $100

Emergency Evacuation with Family Travel Benefit

Maximum Emergency Evacuation Benefit ................................................................. $250,000

Family Travel
- Chosen Person Per Day Allotments
  - for lodging ................................................................................................................ $400
  - for meals .................................................................................................................. $100
- Spouse and Child Per Day Allotments
  - for lodging ................................................................................................................ $400
  - for meals .................................................................................................................. $100
INSURED'S EFFECTIVE AND TERMINATION DATES

Insurance will become effective as to each person in an Eligible Class in consideration of the required premium payment when the Covered Trip begins.

An Insured's insurance ends on the earliest of: (1) the date the Policy is terminated; (2) the date the person is no longer in an Eligible Class; (3) the premium due date if premiums are not paid when due; or (4) the date the Covered Trip ends.

Termination of insurance will not affect a claim for a covered loss that occurred while the Insured's insurance was in force under the Policy.

SOME GENERAL DEFINITIONS USED IN THIS DESCRIPTION OF COVERAGE – Other terms will be defined in the sections where they are used.

Airworthiness Certificate means the “Standard” Airworthiness Certificate issued by the Federal Aviation Agency of the United States of America or its equivalent issued by the governmental authority having jurisdiction over civil aviation in the country of registry.

Civilian Aircraft means a civil or public aircraft having a current and valid Airworthiness Certificate and piloted by a person who has a current and valid medical certificate and pilot certificate with appropriate ratings for the aircraft.

Dependent Child means an Insured’s natural, step, foster, or adopted child or grandchild who is travelling with that Insured who is under age 29 and, except for a grandchild, who is primarily dependent on an Insured for support and maintenance. It will also include an Insured’s child over the above limiting age who is incapable of self-sustaining employment by reason of mental or physical incapacity, and who is primarily dependent on an Insured for support and maintenance, and who is travelling with such Insured.

Domestic Partner means a same or an opposite sex partner who has met all of the following requirements for at least 6 consecutive months immediately preceding the effective date of insurance: (1) resides with the Insured who is under age 29 and, except for a grandchild, who is primarily dependent on an Insured for support and maintenance. It will also include an Insured’s child over the above limiting age who is incapable of self-sustaining employment by reason of mental or physical incapacity, and who is primarily dependent on an Insured for support and maintenance, and who is travelling with such Insured.

Home Country means the country of citizenship of the Insured. If the Insured has dual citizenship, his or her Home Country is the country of the passport he or she used to enter the Host Country.

Host Country means any country in which an Insured is traveling while covered under the Policy.

Hospital means a facility that: (1) is operated according to law for the care and treatment of injured people; (2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (3) has 24 hour nursing service by or under the supervision of registered nurses (R.N.’s); and (4) is supervised by one or more Physicians. A Hospital does not include: (1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes; or (3) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, unless there is a legal obligation to pay.

Immediate Family Member means a person who is related to the Insured in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes S30709NUFIC(Rev.)
stepparent), grandparent, grandchild, brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

**Injury** - means bodily injury: (1) which is sustained as a direct result of an unintended, unanticipated accident that is external to the body and that occurs while the injured person's coverage under the Policy is in force; (2) which occurs while the Insured is on the Trip or Trips specified hereafter; and (3) which directly (independent of Sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a covered loss under one or more of the Benefits described herein.

**Insured** means a person: (1) who is a member of an Eligible Class of persons as described in the Eligibility for Coverage section; (2) for whom premium has been paid; and (3) while covered under the Policy.

**Military Air Transport Aircraft** means an aircraft having a current and valid Airworthiness Certificate; piloted by a person who has a current and valid medical certificate and pilot certificate with appropriate ratings for the aircraft; and operated by the United States of America, or by the similar air transport service of any duly constituted governmental authority of any other recognized country.

**Passenger** means a person not performing as a pilot, operator or crew member of a conveyance.

**Physician** means a licensed practitioner of the healing arts acting within the scope of his or her license who is not: 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

**Specialized Aviation Activity** means an aircraft while it is being used for one or more of the following activities:
- acrobatic or stunt flying
- racing
- any endurance tests
- any flight on a rocket-propelled or rocket-launched aircraft
- crop dusting
- crop seeding
- crop spraying
- fire fighting
- exploration
- pipe line inspection
- power line inspection
- any form of hunting
- bird or fowl herding
- aerial photography
- banner towing
- any test or experimental purpose
- any flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted.

**Spouse** means an Insured’s legal spouse. “Spouse” will also include a domestic or civil union partner as determined by any controlling legal authority or, in the absence of such authority, by agreement between the Company and Policyholder.

**Trip** – means a trip taken by an Insured which begins when the Insured leaves his or her Home Country for the purpose of going on the Trip to the Host Country and is deemed to end when the Insured returns from the Trip to his or her Home Country. However, with respect to the Medical Expense Benefit only, Trip will include any period of time the Insured is in his or her Home Country for a visit or break in a Trip (not to exceed 14 days), provided that Insured returns to the Host Country immediately following such break. “Trip” does not include any trip that extends for more than 180 days.
INSURING PROVISION - COVERED TRIPS

Subject to any exclusions and limitations provided hereafter, an Insured is insured against the losses set forth in this Description of Coverage 24 hours a day during the course of the following Trip or Trips. Such a Trip (or Trips) is (are) referred to as a Covered Trip (or Covered Trips).

24-Hour Protection during the course of a Covered Trip outside of the USA and outside of participant’s home country. Chipmunks soccer team is also a covered activity.

Coverage While on Conveyances – This applies solely to the Accidental Death Benefit, Accidental Dismemberment and Paralysis Benefit.

With respect to any period of time the Insured is traveling on a conveyance during the course of any Covered Trip, the insurance under the Policy only applies with respect to Injury sustained by the person:

1. while operating or riding in or on (including getting in or out of, or on or off of), or by being struck or run down by any conveyance being used as a means of land or water transportation, except:
   a. any such conveyance the Insured has been hired to operate or for which the Insured has been hired as a crew member; or
   b. any such conveyance the Insured is operating, or for which the Insured is performing as a crew member, (including getting in or out of, or on or off of) for the transportation of passengers or property for hire, profit or gain; or
2. while riding as a Passenger in or on (including getting in or out of, or on or off of):
   a. any Civilian Aircraft; or
   b. any Military Air Transport Aircraft; or
3. by being struck or run down by any aircraft.

No benefits are payable for an Injury sustained by an Insured while traveling or flying in or on (including getting in or out of, or on or off of) any aircraft other than as expressly described in this section.

Additionally, no benefits are payable for an Injury sustained by an Insured while traveling or flying in or on (including getting in or out of, or on or off of) any aircraft while it is being used for any Specialized Aviation Activity(ies).

DESCRIPTION OF BENEFITS

Baggage and Personal Effects Benefit

Baggage Delay

If, during the course of a Covered Trip, an Insured's Checked Baggage is delayed or misdirected by a Common Carrier for more than 24 hours from the time the Insured arrives at the destination stated on the Insured’s ticket (except for a return destination) until the time it arrives, the Company will reimburse the Insured for the expense of necessary Personal Effects, up to the Personal Effects Replacement Maximum shown in the Schedule of Benefits.

If the Checked Baggage is delayed after the Insured has reached his or her destination (including a return destination) and the Common Carrier makes a charge for delivery, the Company will reimburse the reasonable cost to deliver the Insured’s Checked Baggage to him/her, up to the Checked Baggage Delivery Charge Maximum shown in the Schedule of Benefits. A copy of the delivery invoice and verification of the delay or misdirection by the Common Carrier must be submitted with the claim.

The Insured must be a ticketed passenger on a Common Carrier. Additionally, all claims must be verified by the Common Carrier who must certify the delay or misdirection. Receipts for the necessary Personal Effects must be submitted with the claim.
Loss of Baggage/Personal Effects

If, during the course of a Covered Trip, an Insured’s Checked Baggage or Personal Effects are lost due to theft, or misdirection by a Common Carrier while the Insured is a ticketed passenger on the Common Carrier, the Company will pay a benefit. The Checked Baggage and Personal Effects must be owned by and accompany the Insured during the Covered Trip.

The Company will reimburse the Insured, up to the Lost Checked Baggage/Personal Effects Maximum shown in the Schedule of Benefits, for the least of the following:

(a) cash value (original cash value, less depreciation as determined by the Company of the baggage and its contents);
(b) the cost of repair; or
(c) the cost of replacement.

There is a Per Article Maximum and a Combined Maximum Limit for the following: jewelry, watches, articles consisting in whole or in part of silver, gold or platinum, furs, articles trimmed with or made mostly of fur, and cameras, including related camera equipment, computer and electronic devices, including but not limited to: portable personal computers, electronic tablets, cell phones, electronic organizers and portable compact disk players. These maximums are shown in the Schedule of Benefits.

All claims must be documented by the Common Carrier.

All items claimed over $150 must be accompanied by an original receipt. If receipts are not provided, benefits may be reduced.

Loss of a Pair/Set

In case of loss to a pair or set, the Company may elect to:

(a) repair or replace any part, to restore the pair or set to its value before the loss; or
(b) pay the difference between the cash value of the property before and after the loss.

Definitions

“Checked Baggage” means a piece of baggage for which a claim check has been issued to the Insured by a Common Carrier.

“Common Carrier” means any land, water or air conveyance operated under a license for the transportation of passengers for hire.

“Personal Effects” means items owned by and for the personal use, adornment or amusement of the Insured.

Limitations

Benefits for Checked Baggage and Personal Effects will be in excess of any amount paid or payable by a Common Carrier or other third party responsible for the loss.

The maximum will be reduced by benefits paid or payable due to any separate maximum under this Benefit.

Exclusions

In addition to any other exclusions or limitations, benefits will not be provided for any loss or damage to:
1. animals;
2. automobiles or automobile equipment;
3. boats;
4. motors;
5. motorcycles;
6. other conveyances or their appurtenances (except bicycles while checked as baggage with a Common Carrier);
7. household furniture;
8. eye glasses, contact lenses or sunglasses;
9. artificial teeth or dental bridges;
10. hearing aids;
11. prosthetic limbs;
12. keys, money, stamps, stocks, bonds, notes or securities accounts, bills, currency, deeds, postal or money orders, food stamps or other evidence of debt, credit cards and other travel documents;
13. tickets, except for administrative fees required to reissue tickets or documents and valuable papers;
14. sporting equipment if loss or damage results from the use thereof;
15. perishables and consumables;
16. contraband, illegal transportation or trade;
17. items seized by any government, government official or customs official;
18. art objects and musical instruments;
19. property shipped as freight, or shipped prior to the date the Insured departs on the Covered Trip;
20. business samples or items;
21. property used in trade, business or for the production of income.

In addition to any exclusions or limitations contained in the Policy, benefits will not be provided for any loss resulting (in whole or in part) from:

1. any unlawful acts, committed by the Insured, an Immediate Family Member or traveling companion;
2. detention, confiscation or destruction by customs;
3. animals, rodents, insects or vermin;
4. confiscation or expropriation by order of any government or public authority; or use of Insured's property for a military purpose;
5. seizure under quarantine or custom regulation;
6. usurped power or action taken by governmental authority in hindering, combating or defending against such an occurrence;
7. transporting contraband or illegal trade;
8. mysterious disappearance.

Payment of Loss: The Insured must: (a) report theft losses to police or other local authorities as soon as possible; (b) take reasonable steps to protect his/her Checked Baggage from further damage and make necessary and reasonable temporary repairs. The Company will reimburse the Insured for those expenses. The Company will not pay for further damage if the Insured fails to protect his/her Checked Baggage; (c) allow the Company to examine the damaged Checked Baggage and/or the Company may require the damaged item to be sent in the event of payment; (d) send sworn proof of loss as soon as possible from date of loss, providing amount of loss, date, time, and cause of loss, and a complete list of damaged/lost items.

Security Evacuation Benefit

If, as a result of an Occurrence that takes place during the course of a Covered Trip and while traveling outside his or her Home Country, an Insured requires a Security Evacuation, the Company will pay benefits to Transport the Insured to the Nearest Place of Safety. The determination that an Insured requires a Security Evacuation must be made by a Designated Security Consultant and all arrangements must be made by Travel Guard Group, Inc.

Benefits will be payable for eligible expenses up to the Maximum Security Evacuation Benefit shown in the Schedule of Benefits. Eligible expenses are for Transportation and Related Costs to the Nearest Place of
Safety necessary to ensure the Insured’s safety and well-being as determined by the Designated Security Consultant. Security Evacuation benefits are payable only once per Occurrence.

Benefits will also be payable for Transportation and Related Costs within 7 days of the Security Evacuation to either of these locations as chosen by the Insured:

(1) back to the Host Country if return is safe and permitted; or
(2) to the Insured’s Home Country.

This benefit is subject to the overall Maximum stated above.

Benefits will be payable for consulting services by Designated Security Consultant for seeking information on Missing Person or kidnapping cases if the Insured is deemed kidnapped or a Missing Person by local or international authorities. This benefit is subject to the overall Maximum stated in the Schedule of Benefits.

Travel Guard Group, Inc. must make all arrangements and must authorize all expenses in advance of any benefits being payable. Travel Guard Group, Inc. is not responsible for the availability of Transport services. Where a Security Evacuation becomes impractical because of hostile or dangerous conditions, a Designated Security Consultant will endeavor to maintain contact with the Insured until a Security Evacuation becomes viable.

Right of Recovery
If, after a Security Evacuation is completed, it becomes clear that the Insured was an active participant in the events that led to an Occurrence, the Company has the right to recover all Transportation and Related Costs from the Insured.

Excess Provision
Benefits payable for the eligible expenses under this Benefit will be limited to that part of the eligible expense, if any, which is in excess of the total benefits payable under any other valid and collectible insurance or other indemnity. If the other valid and collectible insurance or indemnity provides benefits on an excess coverage basis, benefits will be paid first by the insurer or services plan whose coverage has been in effect for the longer period of time.

For purposes of this Benefit, an Insured’s entitlement to other valid and collectible insurance or indemnity will be determined as if this Benefit did not exist and will not depend on whether timely application for benefits from other valid and collectible insurance or indemnity is made by or on behalf of the Insured.

Benefits payable will be reduced to the extent that benefits for expenses are covered by any other valid and collectible insurance or indemnity whether or not a claim is made for such benefits.

Definitions

“Advisory” means a formal recommendation by the Appropriate Authorities that the Insured or citizens of his or her Home Country or citizens of the Host Country leave the Host Country.

“Appropriate Authority(ies)” means the government authority(ies) in the Insured’s Home Country or the government authority(ies) of the Host Country.

“Designated Security Consultant” means an employee of a security firm under contract to Travel Guard Group, Inc. or a Travel Guard Group, Inc. designated service provider who is experienced in security and measures necessary to ensure the safety of the Insured(s) in his or her care.

“Excluded Countries” means the following countries from which Security Evacuations are not available under this Benefit: Iraq, Afghanistan, Pakistan, Israel (West Bank and Gaza Strip), Iran, Somalia and Chechnya or...
any country subject to the administration and enforcement of U.S. economic embargoes and trade sanctions by the OFFICE OF FOREIGN ASSETS CONTROL (OFAC).

“Home Country” means the country of citizenship of the Insured. If the Insured has dual citizenship, his or her Home Country is the country of the passport he or she used to enter the Host Country.

“Host Country” means any country, other than an Excluded Country, in which an Insured is traveling while covered under the Policy.

“Imminent Physical Danger” means the Insured is subject to possible physical injury or Sickness that could result in grave physical harm or death.

“Missing Person” means an Insured who disappeared for an unknown reason and whose disappearance was reported to the Appropriate Authority(ies).

“Natural Disaster” means a 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 of the Host Country and the area is deemed to be uninhabitable or dangerous.

“Nearest Place of Safety” means a location determined by the Designated Security Consultant where:
1. the Insured can be presumed safe from the Occurrence that precipitated the Insured’s Security Evacuation; and
2. the Insured has access to transportation to his or her Home Country; and
3. the Insured has the availability of temporary lodging, if needed.

“Occurrence” means any of the following situations in which an Insured finds him or her self during the course of a Covered Trip:
1. expulsion from a Host Country or being declared persona non-grata on the written authority of the recognized government of a Host Country;
2. political or military events involving a Host Country, if the Appropriate Authorities issue an Advisory stating that citizens of the Insured’s Home Country or citizens of the Host Country should leave the Host Country;
3. Natural Disaster within 10 days of an event;
4. Verified Physical Attack or a Verified Threat of Physical Attack from a third party;
5. the Insured 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 10 days of his or her being found.

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

“Security Evacuation” means the extrication of an Insured from the Host Country due to an Occurrence which results in the Insured being placed in Imminent Physical Danger.

“Transport/Transportation” means the most efficient and available method of conveyance. In all cases, where practical, economy fare will be utilized. If possible, the Insured’s common carrier tickets will be used.

“Verified Physical Attack” means deliberate physical harm of the Insured confirmed by documentation or physical evidence.

“Verified Threat of Physical Attack” means a threat against the Insured’s health and safety as confirmed by documentation and/or physical evidence.
Exclusions

No benefits are payable for charges, fees or expenses:
1. payable under any other provision of the Policy;
2. that are recoverable through the Insured’s employer;
3. arising from or attributable to an actual fraudulent, dishonest or criminal act committed or attempted by an Insured, acting alone or in collusion with others;
4. arising from or attributable to an alleged:
   a. violation of the laws of the Host Country by an Insured; or
   b. violation of the laws of the Insured’s Home Country;
   unless the Designated Security Consultant determines that such allegations were intentionally false, fraudulent and malicious and made solely to achieve a political, propaganda and/or coercive effect upon or at the expense of the Insured;
5. due to the Insured’s failure to maintain and possess duly authorized and issued required travel documents and visas;
6. arising from an Occurrence which took place in an Excluded Country;
7. for repatriation of remains expenses;
8. for common or endemic or epidemic diseases or global pandemic disease as defined by the World Health Organization;
9. for medical services;
10. for monies payable in the form of a ransom if a Missing Person case evolves into a kidnapping;
11. for consulting services seeking information on Missing Person or kidnapping cases;
12. arising from or attributable, in whole or in part, to a debt, insolvency, commercial failure, the repossession of any property by any title holder or lien holder or any other financial cause;
13. arising from or attributable, in whole or in part to non-compliance by the Insured with regard to any obligation specified in a contract or license;
14. due to military or political issues if the Insured’s Security Evacuation request is made more than 7 days after the Appropriate Authority(ies) Advisory was issued;

Quarantine Benefit

If an Insured’s Covered Trip is delayed 24 or more hours due to the Insured’s being in Quarantine, the Company will pay the Per Day Quarantine Benefit shown in the Schedule of Benefits for each calendar day the Insured remains in Quarantine.

The Company will also reimburse the Insured for the following expenses if they are incurred as a direct result of the Insured being in Quarantine:

1. unused, non-refundable travel arrangements or accommodations;
2. any reasonable additional expenses for accommodations; and
3. a one-way economy ticket from the point where the Insured left his or her Covered Trip to a destination where the Insured can rejoin the Covered Trip or a one-way economy ticket to return the Insured to the Insured's Home Country.

The Per Day Quarantine Benefit and the expense incurred benefits set out above are subject to the combined overall Maximum Trip Quarantine Benefit shown in the Schedule of Benefits.

Quarantine means the Insured is forced into medical isolation by a recognized government authority, their authorized deputies, or medical examiners due to the Insured either having, or being suspected of having, a contagious disease, infection or contamination while the Insured is traveling outside of his or her Home Country.

Principal Sum. Some of the Benefits provided hereunder pay a Principal Sum, or a portion thereof for specific losses covered by the Policy. The Principal Sum for each Insured under the Policy is shown in the Schedule of Benefits.
Reduction Schedule. The amount payable for a loss will be reduced if an Insured is age 70 or older on the date of the accident causing the loss with respect to any Benefit provided where the amount payable for the loss is determined as a percentage of his or her Principal Sum. The amount payable for the Insured’s loss under that Benefit is a percentage of the amount that would otherwise be payable, according to the following schedule:

<table>
<thead>
<tr>
<th>AGE ON DATE OF ACCIDENT</th>
<th>PERCENTAGE OF AMOUNT OTHERWISE PAYABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>70-74</td>
<td>65%</td>
</tr>
<tr>
<td>75-79</td>
<td>45%</td>
</tr>
<tr>
<td>80-84</td>
<td>30%</td>
</tr>
<tr>
<td>85 and older</td>
<td>15%</td>
</tr>
</tbody>
</table>

Premium for an Insured age 70 or older is based on 100% of the coverage that would be in effect if the Insured were under age 70.

“Age” as used above, refers to the age of the Insured on the Insured’s most recent birthday, regardless of the actual time of birth.

Aggregate Limit  The maximum amount payable may be reduced if more than one Insured suffers a loss as a result of the same accident, and if amounts are payable for those losses under one or more of the following Benefits: Accidental Death Benefit, Accidental Dismemberment and Paralysis Benefit. The maximum amount payable for all such losses for all Insureds under all those Benefits combined will not exceed the amount the Aggregate Limit shown in the Schedule of Benefits. If the combined maximum amount otherwise payable for all Insureds must be reduced to comply with this provision, the reduction will be taken by applying the same percentage of reduction to the individual maximum amount otherwise payable for each Insured for all such losses under all those Benefits combined.

Accidental Death Benefit
If Injury sustained by an Insured during a Covered Trip results in death within 365 days of the date of accident that caused the Injury, the Company will pay 100% of the Principal Sum.

Accidental Dismemberment and Paralysis Benefit
If Injury sustained by an Insured during a Covered Trip results within 365 days of the date of the accident that caused the Injury, in any one of the Losses specified below, the Company will pay the percentage of the Principal Sum shown below for that Loss:

<table>
<thead>
<tr>
<th>For Loss of</th>
<th>Percentage of Principal Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both Hands or Both Feet</td>
<td>100%</td>
</tr>
<tr>
<td>Sight of Both Eyes</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand and One Foot</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand and the Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>One Foot and the Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>Speech and Hearing in Both Ears</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand or One Foot</td>
<td>50%</td>
</tr>
<tr>
<td>Sight of One Eye</td>
<td>50%</td>
</tr>
<tr>
<td>Speech or Hearing in Both Ears</td>
<td>50%</td>
</tr>
<tr>
<td>Hearing in One Ear</td>
<td>25%</td>
</tr>
<tr>
<td>Thumb and Index Finger of Same Hand</td>
<td>25%</td>
</tr>
<tr>
<td>Paralysis</td>
<td>100%</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>50%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>25%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
</tr>
</tbody>
</table>
“Loss” of a hand or foot means complete severance through or above the wrist or ankle joint. “Loss” of sight of an eye means total and irrecoverable loss of the entire sight in that eye. “Loss” of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. “Loss” of speech means total and irrecoverable loss of the entire ability to speak. “Loss” of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

“Quadriplegia” means the complete and irreversible paralysis of both upper and lower limbs. “Paraplegia” means the complete and irreversible paralysis of both lower limbs. “Hemiplegia” means the complete and irreversible paralysis of the upper and lower limbs on the same side of the body. “Uniplegia” means the complete and irreversible paralysis of one limb. “Limb” means entire arm or entire leg.

If more than one Loss is sustained by an Insured as a result of the same accident, only one amount, the largest, will be paid.

**Exposure and Disappearance.** If by reason of an accident occurring during the course of a Covered Trip, the Insured is unavoidably exposed to the elements and as a result of such exposure suffers a loss for which a benefit is otherwise payable, the loss will be covered under the terms of the Policy.

If the Insured’s body has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the Insured was an occupant while covered under the Policy, then it will be deemed, subject to all other terms and provisions of the Policy, that the Insured has suffered accidental death within the meaning of the Policy.

**Medical Expense Benefit**

If, during the course of a Covered Trip, an Insured suffers an Injury or becomes ill with a Sickness that requires him or her to be treated by a Physician, the Company will pay the Percentage Payable of the Usual and Customary Charges incurred for Covered Medical Services received due to that Injury or Sickness, subject to any Limitations noted below, and up to the Medical Expense Maximum per Insured for that Injury or Sickness. This benefit is payable for such charges incurred outside the Insured’s Home Country (except as specifically provided hereafter) and also within 4 weeks after the date of the accident causing the Injury or the onset of the Sickness.

**Covered Medical Service(s)** means any of the following services and subject to any specified Limitations, if the service is Medically Necessary and recommended or ordered by an attending on-site Physician:

1. Hospital room and board (or, when Medically Necessary, room and board in an intensive care or cardiac care unit); Hospital ancillary services (including, but not limited to, use of the operating room or emergency room);
2. services of a Physician or a registered nurse (R.N.);
3. ambulance service to or from a Hospital;
4. laboratory tests;
5. radiological procedures;
6. anesthetics and the administration of anesthetics;
7. blood, blood products and artificial blood products, and the transfusion thereof; physical therapy and occupational therapy;
8. rental of Durable Medical Equipment, or purchase thereof if less expensive;
9. artificial limbs, artificial eyes or other prosthetic appliances; or
10. medicines or drugs administered by a Physician or that can be obtained only with a Physician’s written prescription.
11. repair of eye glasses, contact lenses or hearing aids when required as a direct result of a covered Injury.

**Note:** Covered Medical Services will also include charges for a hotel room, when the Insured is under the care of a Physician in such hotel room because a Hospital room is not available by reason of capacity or distance or any other circumstances beyond the control of the Insured.
Maximums, Deductible

Medical Expense Maximum Benefit. In no event shall the total amount payable to or on behalf of any one Insured for all covered Medical Services for any one Injury or Sickness covered under this Benefit exceed the Medical Expense Maximum Benefit shown in the Schedule of Benefits.

Plan Deductible. The Plan Deductible is a dollar amount of Usual and Customary Charges for Medically Necessary Covered Medical Services which must be incurred as an out-of-pocket expense by each Insured due to any one Injury or Sickness before benefits are payable for those services. Benefits are not payable for charges applied to the Plan Deductible. The Insured is responsible for payment of the Plan Deductible. The Plan Deductible is shown in the Schedule of Benefits.

Charges Incurred in the Insured’s Home Country

Under the following circumstances, benefits will be payable for charges incurred for Covered Medical Services provided in the Insured’s Home Country:

- If an Insured’s coverage ends because a Covered Trip ends, and that Insured has a medical condition that was diagnosed while on the Covered Trip and while in the Host Country, benefits will be payable for treatment of that condition in the Home Country for a maximum of 90 days from the date coverage ends.
- If, while on a Covered Trip, the Insured returns to his or her Home Country for a break or visit, benefits will be payable for treatment of a covered medical condition that is provided in the Home Country, subject to the Home Country Maximum shown in the Schedule of Benefits.

Limitations

Medical Expense Benefits are subject to the limitations shown in the Schedule of Benefits.

Definitions. The following terms are defined as follows:

“Durable Medical Equipment” refers to equipment of a type that is designed primarily for use, and used primarily, by people who are injured (for example, a wheelchair or a hospital bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of injury or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

"Emergency Medical Condition“ means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
1. Placing the health of the Insured in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

“Sickness” means an illness, infection or disease which requires treatment by a Physician. Sickness includes Complications of Pregnancy.

"Complications of Pregnancy“ means conditions requiring Hospital stays (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also include non-elective caesarean section, ectopic pregnancy, which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.
Complications of Pregnancy does not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

“Medically Necessary” refers to a Covered Medical Service that: (1) is essential for diagnosis, treatment or care of the or condition for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; (3) is not primarily for the convenience of the Insured, Physician, other providers or any other person, and (4) is ordered by a Physician and performed under his or her care, supervision or order.

"Pre-Existing Condition" means a condition for which the Insured received any diagnosis, medical advice or treatment or had taken any prescription medicines during the 24 months immediately preceding the effective date of the Insured’s coverage under the Policy unless the condition for which the prescribed medication is taken remains controlled without any change in the required prescription. A Complication of Pregnancy is not considered a pre-existing condition. Pregnancy is considered a pre-existing condition if conception occurs prior to the effective date of the Insured’s coverage.

“Usual and Customary Charge(s)” means a charge that: (1) is made for a Covered Medical Service; (2) does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred (for a Hospital room and board charge, other than for a Medically Necessary stay in an intensive care unit or a cardiac care unit, does not exceed the Hospital's most common charge for semi-private room and board); and (3) does not include charges that would not have been made if no insurance existed.

Exclusions. In addition to the Exclusions in the General Exclusions section, benefits are not payable for, and Usual and Customary Charges for Covered Medical Services do not include, any expense for or resulting from:

1. repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or rented existing Durable Medical Equipment unless for the purpose of modifying the item because the Injury or Sickness has caused further impairment in the underlying bodily condition.
2. new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except as may be provided above.
3. new eye glasses or contact lenses or eye examinations related to the correction of vision or related to the fitting of glasses or contact lenses, unless the Injury or Sickness has caused impairment of sight; or repair or replacement of existing eyeglasses or contact lenses unless for the purpose of modifying the item because the Injury or Sickness has caused further impairment of sight.
4. new hearing aids or hearing examinations unless the Injury or Sickness has caused impairment of hearing; or repair or replacement of existing hearing aids unless for the purpose of modifying the item because the Injury or Sickness has caused further impairment of hearing.
5. rental of Durable Medical Equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (but if, in the Company’s sole judgment, Benefits for rental of Durable Medical Equipment are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the Company may, but is not required to, choose to consider such purchase expense as a Usual and Customary Covered Medical Expense in lieu of such rental expense).
6. personal comfort or convenience items, such as but not limited to Hospital telephone charges, television rental, or guest meals.
7. private duty nursing services.
8. services, supplies or treatment, which were not recommended, approved and certified as necessary and reasonable by the attending, onsite Physician.

9. Injury sustained while participating in professional, interscholastic, intercollegiate athletics, including officiating or coaching; or racing any type vehicle in an organized event.

10. cosmetic care, except for reconstructive plastic surgery required as a result of Injury.

11. elective surgery which can be postponed until the Insured returns to his or her country of residence.

12. treatment of Temporomandibular Joint (TMJ) Dysfunction.

13. treatment of congenital anomalies and conditions arising out of or resulting therefrom.

14. services and supplies which are not due to an Injury or Sickness except as may be specifically provided.

15. Injury sustained while driving any vehicle for wage, compensation, or profit.

16. Injury sustained while caving, ice-climbing; parachuting, skydiving, skin diving, para-sailing, paragliding, hot air ballooning, bungee jumping, uncertified scuba, deep sea diving, hang gliding, extreme sports, ultralight flying, trampoline jumping, snow skiing, lugeing, snow sports, snowboarding, tobogginaging, bobsledding, snow tubing, ice hockey.

17. services or supplies which are experimental or investigative in nature; including the treatment, procedure, facility, equipment, drugs, drug usage, devices or supplies not recognized as accepted medical practice and any such items requiring federal or other governmental agency approval not received at the time services were rendered.

18. Injury sustained or Sickness contracted as a result of the Insured’s commission of or attempt to commit a felony.

19. services rendered by a member of the Insured’s Immediate Family or by a person who resides with the Insured.

20. treatment of weak, strained or flat feet, corns, calluses, bunions or toenails.

21. treatment rendered within the Insured’s Home Country, except as otherwise provided herein.

22. treatment in connection with birth control, sterilization or sterilization reversal, including surgical procedures and devices.

23. outpatient treatment in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purposes of removing the nerve interference as a result of or related to distortion, misalignment or subluxation of or in the vertebral column except as provided herein.

24. diagnostic or surgical procedures in connection with infertility unless caused by a covered Injury or Sickness.

25. maintenance therapy which is defined as therapy services rendered to an Insured who is no longer making documentable progress, to maintain the level of progress previously attained.

26. treatment for weight increase or reduction, or hair growth or removal.

27. routine physical examinations and related medical services.

28. vocational therapy, recreational therapy, music therapy or speech therapy.

29. Injuries for which benefits are payable under any no-fault automobile Insurance Policy.
30. diagnosis or treatment of acne.

31. human organ or tissue transplants or treatment thereof.

32. a motor vehicle accident if the Insured is not properly licensed to operate the motor vehicle in the jurisdiction in which the accident takes place (This exclusion will not apply to an Insured who is a passenger.

33. treatment of any condition for which the Insured is entitled to benefits under any Workers’ Compensation Act or similar law.

Medical Emergency Guarantee Charge Expense Benefit. If during the course of a Covered Trip, an Insured suffers an Emergency Medical Condition for which Medical Expense benefits become payable and such person incurs a Hospital Admission Guarantee Charge and/or a Medical Expense Guarantee Charge, the Company will pay the actual expenses incurred for guarantee of the payment to the Hospital or the medical provider up to a the Maximum Medical Emergency Guarantee Charge Expense Benefit shown in the Schedule of Benefits.

• “Hospital Admission Guarantee Charge” means any charge or expense made by a Hospital prior to and as a condition of an Insured’s admission to that Hospital.

• “Medical Expense Guarantee Charge” means any charge or expense made by a medical provider other than a Hospital prior to and as a condition of an Insured’s being provided with the medical service or treatment by that provider.

The Medical Expense Maximum Benefit will be reduced by any amounts paid or payable under this Medical Emergency Guarantee Charge Expense Benefit.

Repatriation of Remains with Family Travel Benefit
If during the course of a Covered Trip, an Insured suffers loss of life due to Injury or Emergency Sickness, the Company will pay for covered expenses reasonably incurred to return his or her body to his or her Home Country place of primary residence, up to the Maximum Repatriation of Remains Benefit shown in the Schedule of Benefits.

Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

Following an Insured’s death for which a Repatriation of Remains benefit is payable, the Company will pay for expenses reasonably incurred:

1. to return to their Home Country place of primary residence the Insured’s Spouse and any of the Insured’s Dependent Children who were accompanying the Insured when his or her death occurred, with an attendant for the children if necessary and if they are not accompanied by the Spouse; but not to exceed the cost of a single one-way economy airfare ticket less the value of applied credit from any unused return travel tickets per person; and

2. for lodging and meals for up to 7 days for the Insured’s Spouse and Dependent Children in the area where the Insured’s death occurred, if they were accompanying the Insured at that time. The Company will only pay for such expenses for days in excess of the days that had been planned for the trip prior to the Insured’s death, and only prior to the repatriation of his or her remains. The Company will not pay for such expenses in excess of, for the Spouse and Dependent Children combined, $100 per day for lodging and $75 per day for food.
Travel Guard Group, Inc. must make all arrangements and must authorize all expenses in advance for any benefits under this Benefit to be payable. The Company reserves the right to determine the benefit payable, including reductions, if it is not reasonably possible to contact Travel Guard Group, Inc. in advance.

“Emergency Sickness” means an illness, infection or disease, diagnosed by a Physician, which meets all of the following criteria: (1) there is present a severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Insured's condition or place his or her life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs while the Policy is in force as to the person suffering the symptom and during the course of a Covered Trip.

The General Exclusions section and any exclusions in the Covered Trips section, do not apply with respect to this Benefit.

Attendor Benefit
If a Repatriation of Remains benefit becomes payable, the Company will also pay for expenses reasonably incurred for one person (referred to as the Attendor) to accompany (on the same vehicle where possible) the deceased Insured’s remains from the place where death occurred to the deceased Insured’s place of primary residence in the Home Country; but not to exceed the cost of one round-trip economy airfare ticket. The Company will also pay for the Attendor’s lodging and meals for up to 7 days, but: (a) only while the Attendor is away from his or her place of primary residence in connection with accompanying the deceased Insured’s remains as described above; and (b) not to exceed the Per Day Allotments Shown in the Schedule of Benefits.

Travel Guard Group, Inc. must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Guard Group, Inc. in advance.

Bedside Visit Benefit.
If, during the course of a Covered Trip, an Insured suffers an Injury or becomes ill with a Sickness and is confined to a Hospital or other medical facility for 6 days or more due to such Injury or Sickness, the Company will pay for expenses reasonably incurred to bring one person chosen by the Insured to and from the Hospital or other medical facility where the Insured is confined, if the Insured is alone and if the place of confinement is outside a 100 mile radius from the Insured’s current place of residence in the Host Country; but not to exceed the cost of one round-trip economy airfare ticket. The Company will also pay for lodging and meals for up to 10 days for such person in the area of such place of confinement, but: (a) only while the Insured remains so confined; and (b) not to exceed the Per Day Allotments Shown in the Schedule.

Travel Guard Group, Inc. must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Guard Group, Inc. in advance.

Definitions
“Sickness” means an illness, infection or disease which requires treatment by a Physician. Sickness includes Complications of Pregnancy.

"Complications of Pregnancy" means conditions requiring Hospital stays (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also include non-elective caesarean section, ectopic pregnancy, which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
Emergency Evacuation with Family Travel Benefit.
The Company will pay for Covered Emergency Evacuation Expenses reasonably incurred if, during the course of a Covered Trip, an Insured suffers an Injury or Emergency Sickness that warrants his or her Emergency Evacuation, up to the Maximum Emergency Evacuation Benefit shown in the Schedule of Benefits for all Emergency Evacuations due to all Injuries from the same accident or all Emergency Sicknesses from the same or related causes.

The Physician ordering the Emergency Evacuation must certify that the severity of the Insured's Injury or Emergency Sickness warrants his or her Emergency Evacuation. All Transportation arrangements made for the Emergency Evacuation must be by the most direct and economical conveyance and route possible.

Family Travel Benefit. Following an Emergency Evacuation for which an Emergency Evacuation benefit is payable, the Company will pay for expenses reasonably incurred:

1. to return the Insured’s Spouse and any of the Insured’s Dependent Children who were accompanying the Insured when his or her Injury or Emergency Sickness occurred, with an attendant for the children if necessary and if they are not accompanied by the Spouse; to the location to which the Insured is being evacuated or, at the Company’s discretion, to the Insured’s Spouse’s or Insured’s Dependent Child’s place of primary residence in their Home Country, but not to exceed the cost of a single one-way economy airfare ticket less the value of applied credit from any unused return travel tickets per person; and.

2. to bring one person chosen by the Insured to and from the hospital or other medical facility where the Insured is confined if the Insured is alone and if the place of confinement is outside a 100 mile radius from the Insured’s current place of primary residence in the Host Country; but not to exceed the cost of one round-trip economy airfare ticket.

3. for lodging and meals for up to 7 days for such chosen person in the area of such place of confinement, but: (a) only while the Insured remains so confined; and (b) not to exceed the Chosen Person Per Day Allotments shown in the Schedule of Benefits.

4. for lodging and meals for up to 7 days for the Insured’s Spouse and Dependent Children in the area where the Insured is confined, if: (a) they were accompanying the Insured when the Emergency Evacuation became necessary; and (b) the place of confinement is outside a 100 mile radius from the Insured’s current place of primary residence in the Host Country. The Company will only pay for such expenses for days in excess of the days that had been planned for the trip prior to the Insured’s Emergency Evacuation, and only while he or she remains so confined. The Company will not pay for such expenses in excess of, for the Spouse and Dependent Children combined, the Spouse and Child Per Day Allotments shown in the Schedule of Benefits.

Travel Guard Group, Inc. must make all arrangements and must authorize all expenses in advance for any benefits under this Benefit to be payable. The Company reserves the right to determine the benefit payable, including reductions, if it is not reasonably possible to contact Travel Guard Group, Inc. in advance.

The General Exclusions section and the exclusions under Insuring Provision – Covered Trip do not apply to this Benefit.

Definitions

“Covered Emergency Evacuation Expense(s)” means an expense that: (1) is charged for a Medically Necessary Emergency Evacuation Service; (2) does not exceed the usual level of charges for similar Transportation, treatment, services or supplies in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.
“Emergency Evacuation” means, if warranted by the severity of the Insured’s Injury or Emergency Sickness: (1) the Insured's immediate Transportation from the place where he or she suffers an Injury or Emergency Sickness to the nearest hospital or other medical facility where appropriate medical treatment can be obtained; (2) the Insured's Transportation to his or her current place of primary residence in the Host Country or, at the Company’s discretion, to his or her place of primary residence in the Home Country to obtain further medical treatment in a hospital or other medical facility or to recover after suffering an Injury or Emergency Sickness and being treated at a local hospital or other medical facility; or (3) both (1) and (2) above. An Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.

“Emergency Sickness” means an illness, infection or disease, diagnosed by a Physician, which meets all of the following criteria: (1) there is present a severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Insured's condition or place his or her life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs during the course of a Covered Trip. For purposes of this Benefit, any references to “Injury” are deemed to be references to “Injury or Emergency Sickness.”

“Medically Necessary Emergency Evacuation Service” means any Transportation, medical treatment, medical service or medical supply that: (1) is an essential part of an Emergency Evacuation due to the Injury or Emergency Sickness for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) either is ordered by a Physician and performed under his or her care or supervision or order, or is required by the standard regulations of the conveyance transporting the Insured.

“Transportation” means moving the Insured during an Emergency Evacuation by a land, water or air conveyance. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.

LIMITATIONS

Limitation on Multiple Benefits. If an Insured suffers one or more losses from the same accident for which amounts are payable under more than one of the following Benefits, the maximum amount payable under all Benefits combined will not exceed the amount payable for one of those losses, the largest: Accidental Death Benefit, Accidental Dismemberment and Paralysis Benefit.

Limitation on Benefits under Multiple Accident Plans. If an Insured is covered under one or more same type accident plans for the same Policyholder underwritten by the Company or any of its affiliates; and if the Insured suffers a loss from an accident for which one or more Benefits are payable under more than one same type accident plan for that Policyholder, the maximum amount payable under all of the Benefits combined will not exceed the amount payable for one of those losses, the largest, subject to the maximum amount payable under such accident plan with the largest maximum. Benefit payments will be payable under only accident plan.

Excess Benefits Provision

I. Applicability. This Excess Benefits provision applies to This Plan when an Insured has health care coverage under more than one Plan. “Plan” and “This Plan” are defined in Section II “Definitions.” The benefits of This Plan may be reduced when benefits are also payable under another Plan. This reduction is described in Section IV “Effect on the Benefits of This Plan.”

II. Definitions.

A. “Plan” is any of these which provides benefits or services for, or because of, health care:
   (1) Group, group-type, family or individual insurance contracts;
   (2) Group, group-type, family or individual subscriber contracts;
   (3) Uninsured arrangements of group, group-type, family or individual coverage;
(4) Group, group-type, family or individual coverage through health maintenance organizations and other prepayment, group practice and individual practice plans;

(5) The medical benefits coverage in group, group-type, family and individual automobile “no-fault” and traditional automobile “fault” type contracts; and

(6) Coverage under a governmental plan or coverage required or provided by law; but not including: (a) a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); or (b) a plan or law when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

“Group-type” refers to contracts or coverages that are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts and coverages answering this description are included in the definition of a Plan whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, “franchise” or “blanket”).

Each contract or other arrangement for coverage described in this Subsection II(A) is a separate Plan. Also, if an arrangement has two parts and Excess Benefits rules apply only to one of the two, each of the parts is a separate Plan.

B. “This Plan” is any part of the Policy that provides Medical Expense benefits.

C. “Primary Plan/Secondary Plan”: The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the Insured. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits. When there are more than two Plans covering the Insured, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

D. “Allowable Expense” means a necessary, reasonable and customary item of expense for health care to the extent that the expense both is a Covered Expense under the Policy and is covered at least in part by one or more other Plans covering the Insured. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered is both an Allowable Expense and a benefit paid, to the extent that the reasonable cash value of the service would be a Covered Expense under the Policy.

III. Order of Benefit Determination Rules. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

A. The other Plan has coordination of benefits or excess benefits rules that require that This Plan’s benefits be determined before those of the other Plan; and

B. This Plan has covered the Insured longer than the other Plan has.

IV. Effect on the Benefits of This Plan.

A. When This Section Applies. This Section IV applies when, in accordance with Section III “Order of Benefit Determination Rules,” This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as “the other Plans” in Subsection below.

B. Reduction in This Plan’s Benefits. The benefits of This Plan for Allowable Expenses will be reduced by the amount of the benefits that would be payable for those Allowable Expenses under the other Plans, in the absence of provisions with a purpose with a purpose like that of a
coordination of benefits provision or this Excess Benefits provision, whether or not claim is made.

V. **Right to Receive and Release Needed Information.** Certain facts are needed to apply these Excess Benefits rules. The Company has the right to decide which facts the Company needs. The Company may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Company any facts the Company needs to pay the claim.

VI. **Facility of Payment.** A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, The Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

VII. **Right of Recovery.** If the amount of the payments made by the Company is more than the Company should have paid under this Excess Benefits provision, The Company may recover the excess from one or more of:
   A. The persons the Company has paid or for whom the Company has paid;
   B. Insurance companies; or
   C. Other organizations.
GENERAL EXCLUSIONS

No coverage shall be provided under the Policy and no payment shall be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the loss is an accidental bodily Injury:

1. suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury or auto-eroticism.
2. declared or undeclared war, or any act of declared or undeclared war.
3. with respect to any benefit that is triggered by an accidental Injury only, Sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these.
4. with respect to any benefit that is triggered by an accidental Injury only, infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying Sickness, disease or condition including but not limited to diabetes.
5. full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured is not covered due to his or her active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.)
6. the Insured’s being under the influence of intoxicants while operating any vehicle or means of transportation or conveyance.
7. the Insured’s being under the influence of drugs unless taken under the advice of and as specified by a Physician.
8. the Insured’s commission of or attempt to commit a crime.
9. caving, ice-climbing; parachuting, skydiving, skin diving, para-sailing, paragliding, hot air ballooning, bungee jumping, uncertified scuba, deep sea diving, hang gliding, extreme sports, ultralight flying, trampoline jumping, snow skiing, lugeing, snow sports, snowboarding, tobogganing, bobsledding, snow tubing, ice hockey.
CLAIMS PROVISIONS

Notice of Claim. Written notice of claim must be given to the Company within 20 days after an Insured's loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company at AIG Accident and Health Claims Department, P.O. Box 25987, Shawnee Mission, KS 66225, with information sufficient to identify the Insured, is deemed notice to the Company.

Claim Forms. The Company will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the Insured's name, the Policyholder's name and the Policy number.

Proof of Loss. Written proof of loss must be furnished to the Company within 90 days after the date of the loss. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as The Company may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Payment of Claims. Upon receipt of due written proof of death, payment for loss of life of an Insured will be made to the Insured's beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured suffering the loss. If an Insured dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

The refusal of a Physician or Hospital to make all medical reports and records available to the Company will cause an otherwise valid claim to be denied.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

With respect to losses suffered by Insureds whose permanent residence is outside the United States of America or Canada, the Company will pay any benefits that may become payable under the Policy to the Policyholder, who:

1. will hold such payment in trust for the sole use and benefit of the Insured or his or her beneficiary or other person to whom such benefits are payable (the Payee), as described in this Payment of Claims provision;
2. will transmit such payment to such Payee in accordance with the Payment of Claims, Time of Payment of Claims, and Beneficiary Designation and Change provisions of the Claims Provisions and General Provisions sections;
3. agrees that any such payment made by the Company to the Policyholder constitutes a full discharge of the Company's liability with respect to the claim for which payment is made;
4. will alone assume full responsibility for the proper application or distribution of such payment;
5. will indemnify, defend and hold the Company harmless for any claims, demands, judgments, losses, costs, expenses, liabilities and damages whatsoever, including interest, penalties and legal fees, arising from or relating in any way to such payment or to the amount, application or distribution thereof;
6. with respect to any application or disbursement of such payment in foreign currency, will use the foreign exchange rate in effect at the Policyholder’s payor bank on the date the benefits become payable to convert United States of America dollar-denominated currency into foreign currency.

Any payment the Company makes in good faith fully discharges its liability to the extent of the payment made

**Time of Payment of Claims.** Benefits payable for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon the Company’s receipt of due written proof of the loss. Subject to the Company’s receipt of due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

**GENERAL PROVISIONS**

**Incontestability.** No statement by the Insured, except a fraudulent one, will be used to contest a claim under the Policy. The Company may only contest coverage if the misstatement is made in a written instrument signed by the Insured and a copy is given to the Policyholder, the Insured or the Insured’s beneficiary.

**Legal Actions.** No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished.

**Beneficiary Designation and Change.** The Insured’s designated beneficiary(ies) is (are) the person(s) so named by the Insured as shown on the records.

An Insured over the age of majority and legally competent may change his or her beneficiary designation at any time, unless an irrevocable designation has been made, without the consent of the designated beneficiary(ies, by providing the Policyholder with a written request for change. When the request is received, whether the Insured is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the Company on account of any payment made by it prior to receipt of the request.

If there is no designated beneficiary for an Insured’s coverage or no designated beneficiary for the Insured’s coverage is living after the Insured’s death, the benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: the Insured’s (1) spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is the Insured’s estate.

**Physical Examination and Autopsy.** The Company at its own expense, has the right and opportunity to examine the person of any individual whose loss is the basis of claim under the Policy when and as often as the Company may reasonably require during the pendency of the claim and to make an autopsy in case of death where it is not forbidden by law.

**Assignment.** An Insured may not assign any of his or her rights, privileges or benefits under the Policy.