GROUP INBOUND TRAVEL INSURANCE POLICY

Policyholder:	**Global Trust**
Policyholder Address:	**ITA BANK AND TRUST COMPANY LTD** **Suite 4210, 2nd Floor Canella Court** **48 Market St** **Camana Bay** **PO Box 32203** **Grand Cayman KY1-1208** **Cayman Islands**
Participating Organization:	**Peninsula College**
Policy Number:	**LMB-556677- 512**
Effective Date:	**September 19, 2016**
Expiration Date:	**September 18, 2017**
Rates:	**As attached**
UMR:	**B1921YA000410P**

The Policy is a legal contract between the Policyholder and Brit Syndicates Limited on behalf of Syndicate 2987 at Lloyd's (herein referenced as "the Company") and is issued by Global Benefits Group, Inc., 27422 Portola Parkway, Suite 110, Foothill Ranch, California 92610, USA acting as agent for the Underwriters pursuant to an authority granted under Binding Authority Agreement reference UMR: B1921YA000410P.

The Company agrees to provide insurance, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in the Policy.

The Company and the Policyholder have agreed to all the terms and conditions of the Policy.

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

THIS IS LIMITED BENEFIT COVERAGE. READ IT CAREFULLY. THIS POLICY IS NOT RENEWABLE

Important notices regarding the Patient Protection and Affordable Care Act (PPACA)

Important Notice to US Citizens/Residents regarding the Patient Protection and Affordable Care Act: This insurance is not subject to, and does not provide certain of the insurance benefits required by the United States' Patient Protection and Affordable Care Act ("ACA"). This insurance does not provide, and the Company does not intend to provide, minimum essential coverage under ACA. This is limited benefit coverage. In no event will Benefits be provided in excess of those specified in this Policy. The Plan Participant should consult their attorney or tax professional to determine if ACA's requirements are applicable to them.

Program managed and administered by
The Lewer Agency, Inc.
4534 Wornall Road
Kansas City, MO 64111
800.821.7715
(the "Program Manager")

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SCHEDULE OF BENEFITS

Policyholder:	**Global Trust**
Participating Organization:	**Peninsula College**
Plan Participant:	**Peninsula College**
Policy Number:	**LMB-556677- 512**
Effective Date:	**September 19, 2016**
Expiration Date:	**September 18, 2017**
Premium Due Date:	**Quarterly**

CLASSES OF ELIGIBLE PERSONS:

A person may be covered only under one Class of eligible persons even though He or She may be eligible under more than one class. Also, a person may not be covered as a Dependent and a Plan Participant at the same time.

Class 3: Non-United States Citizens traveling outside their Home Country, has his or her true, fixed and permanent home and principal establishment outside of the United States, and holds a current and valid passport, while actively engaged in educational or research activities. For purposes of this Eligible Class You are "actively engaged" in educational activity if you are one of the following:

1. F1/J1 valid visa holder. (An F1 visa holder on OPT may be eligible up to 12 months); or
2. Undergraduate student registered for and attending classes on a full-time basis; or
3. Graduate student; or
4. Scholar or researcher who is invited by an educational organization; or
5. Student involved in education, educational activities, or research related activities.

ACCIDENT AND SICKNESS BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Class 3 Principal Sum: **$10,000**

Time Period for Loss: **within 90 days of the Covered Accident**

Loss of	Benefit (Percentage of Principal Sum)
Loss of Life	100%
Brain Death	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing (both ears)	100%
Quadriplegia (total Paralysis of both upper and lower limbs)	100%
Paraplegia (total Paralysis of both lower or upper limbs)	50%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Speech	50%
Loss of Hearing (both ears)	50%
Hemiplegia (total Paralysis of upper and lower limbs on one side of body)	50%
Uniplegia (total Paralysis of one lower or upper limb)	25%
Loss of Thumb and Index Finger of the Same Hand	25%

ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS

Benefits will be provided only for the Coverages listed below and will be paid only up to the amounts shown.

Policy Benefits – Per Covered Student	
Policy Term Maximum for all Injury and Sickness	$500,000
Deductible Per Plan Participant Per Injury or Sickness:	**Network/Non-Network Provider:** $0
Copay at Student Health Center:	None
Out-of-Pocket Maximum Per Plan Participant:	$3,000
Pre-Existing Condition Benefit: First six months of continuous coverage	$2,500

Per Injury or Sickness:	
Coinsurance:	**In-Network:** 100% of the Preferred Allowance
	Out-of-Network: 80% of Usual, Reasonable & Customary (URC) Charges
Co-Payment:	**Provider Office Visit:** $20 **Hospital Visit:** $100 **Emergency Room Visit**: $100
Lifetime Maximum	$500,000
Any Coinsurance, Co-payments, and Benefit Maximums apply on a per Plan Participant basis.	

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

BENEFIT COVERAGE	BENEFIT AMOUNT	
	In-Network Provider Benefit	**Out-of-Network Provider Benefit**
Hospital Room & Board Benefit	100% of the Preferred Allowance	80% of the Semi-Private Room Rate
Intensive Care Unit Benefit	100% of the Preferred Allowance	80% of URC
Surgeon (In or Outpatient) Benefits	100% of the Preferred Allowance	80% of URC
Assistant Surgeon Benefit	100% of the Preferred Allowance	80% of URC
Anesthesia Benefit	100% of the Preferred Allowance	80% of URC
Diagnostic X-Ray and Lab Benefit	100% of the Preferred Allowance	80% of URC
Ambulance Benefit	100% of the Preferred Allowance	80% of URC
Physician Visit Benefit (Inpatient)	100% of the Preferred Allowance	80% of URC
Physician Visit Benefit (Outpatient)	100% of the Preferred Allowance	80% of URC
Radiation/Chemotherapy Benefit	100% of the Preferred Allowance	80% of URC
Intercollegiate/Interscholastic Sports Benefit	Not Covered	Not Covered
Emergency Room Benefit	100% of the Preferred Allowance	80% of URC
Infusion Therapy Benefit	100% of the Preferred Allowance up to a maximum of $10,000 per policy year	80% of URC up to a maximum of $10,000 per policy year
Renal Dialysis/Hemodialysis Benefit	100% of the Preferred Allowance up to a maximum of $10,000 per policy year	80% of URC up to a maximum of $10,000 per policy year
Post-Mastectomy Coverage Benefit	100% of the Preferred Allowance	80% of URC
Wellness Benefit (Maximum Benefit of $250 per policy year)	100% of charges for care received at a Student Health Center or approved Walk-In Pharmacy Clinics, **50% of charges for care received at other providers**	100% of charges for care received at a Student Health Center or approved Walk-In Pharmacy Clinics, **50% of charges for care received at other providers**
Maternity and Pre-Natal Care Expense Benefit (Conception must occur while covered under the Policy)	100% of the Preferred Allowance	80% of URC
Allergy Treatment Benefit (Medically Necessary treatment of allergies, as diagnosed and prescribed by a Physician)	100% of the Preferred Allowance	80% of URC
Emergency Dental Expense Benefit up to a maximum benefit of $2,500	100% of the Preferred Allowance	80% of URC

BENEFIT COVERAGE	BENEFIT AMOUNT	
	In-Network Provider Benefit	**Out-of-Network Provider Benefit**
MENTAL & NERVOUS CONDITIONS EXPENSE BENEFIT		
In-Patient Expense (30 days maximum)	100% of the Preferred Allowance	80% of URC
Out-Patient Expense (10 visits maximum)	100% of the Preferred Allowance	80% of URC
ALCOHOL & DRUG ABUSE EXPENSE BENEFIT		
In-Patient Expense (30 days maximum)	100% of the Preferred Allowance	80% of URC
Out-Patient Expense (10 visits maximum)	100% of the Preferred Allowance	80% of URC

Self-Inflicted Injury Benefit	100% of the Preferred Allowance up to a maximum of $10,000 per policy year	80% of URC up to a maximum of $10,000 per policy year

PHYSIOTHERAPY BENEFITS		
Physiotherapy Expense Benefit - Inpatient	100% of the Preferred Allowance	80% of URC
Physiotherapy Expense Benefit – Outpatient **Only when prescribed in writing by a Physician**	100% of the Preferred Allowance for up to a maximum of 12 visits for each of: • **physical therapy** • **acupuncture** • **chiropractics**	80% of URC for up to a maximum of 12 visits for each of: • **physical therapy** • **acupuncture** • **chiropractics**
Durable Medical Equipment Expense Benefit **Only when prescribed in writing by a Physician**	100% of the Preferred Allowance	80% of URC

ADDITIONAL BENEFITS	
Medical Evacuation Benefit	Up to $50,000 of Reasonable Expenses
Repatriation Benefit	Up to $25,000 of Reasonable Expenses
Continuation Benefit	Available up to a maximum of 13 weeks or up to a Maximum Benefit of $10,000, whichever is reached first

Prescription Drug Benefits	
Dispensed by a Student Health Center	100% of each 30 day supply
Dispensed by a Participating Network Pharmacy	50% of each 30 day supply
Prescription Oral Contraceptives	100% of each 30 day supply dispensed by a Student Health Center; 50% of each 30 day supply dispensed by a Participating Network Pharmacy
Dispensed while Inpatient at a Hospital	100% In-Network Hospital 80% Out of Network Hospital
With respect to outpatient prescriptions, the Policy will pay the stated percentage for each 30 day supply, until the stated Prescription Drug Benefit Maximum has been met.	

NOTES:

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

NETWORK PROVIDER ARRANGEMENTS

Network contracted providers and some walk-in clinics have agreed to accept special reduced reimbursement rates for treatment rendered to students. Eligible services provided by **these providers** will be paid at 100% of these negotiated rates.

You will be responsible for all out of pocket expenses in excess of the insurance policy benefits based on the limitations contained in the Schedule of Medical Expense Benefits.

DEFINITIONS

The male pronoun includes the female whenever used.
For the purposes of the Policy the capitalized terms used herein are defined as follows:
Additional terms may be defined within the provision to which they apply.

Accident means an unforeseeable event which:

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

Application means the Plan Participants Application for inclusion under the Master Policy.

Average Semiprivate Charge means (1) the standard charge by the Hospital for semiprivate room and board accommodations, or the average of such charges where the Hospital has more than one established level of such charges, or (2) 80% of the lowest charge by the Hospital for single bed room and board accommodations where the Hospital does not provide any semiprivate accommodations.

Class means a group of people defined by a common characteristic, including but not limited to demographic group and geographic region**.**

Coinsurance means the percentage of Eligible Expenses for which the Company is responsible for a specified covered service after the copay, Deductible, if any, has been met.

Company means Syndicate 780 at Lloyd's. Also hereinafter referred to as We, Us and Our.

Complications of Pregnancy means a condition which:

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

Complications of Pregnancy will not include:

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

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

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

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

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

Covered Loss or Covered Losses means an accidental death, dismemberment or other Injury covered under the Policy and indicated on the Schedule of Benefits.

Custodial Care means that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Plan Participant, whether or not totally disabled, in the activities of daily living.

Dentist means a legally licensed doctor of dental surgery; dental medicine or dental science. A dental hygienist who works within the scope of his/her license, under the supervision of a Dentist, is a covered practitioner.

Eligible Expenses means the Preferred Allowance or Usual, Reasonable and Customary charges for services or supplies which are incurred by the Plan Participant for the Medically Necessary treatment of an Injury. Eligible Expenses must be incurred while the Policy is in force.

Emergency means an Injury or Sickness for which the Plan Participant seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause:

- His life or health would be in serious jeopardy, or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;
- His bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

Experimental/Investigational means that a drug, device or medical care or treatment will be considered experimental/investigational if:

- The drug or device cannot be lawfully marketed without approval of the Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
- Reliable Evidence show that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or
- Reliable Evidence show that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device or medical care at the time the expense is incurred.

Management staff in Our Claims Department or a Claims Payor acting on Our behalf will make the determination if the drug, device or medical care is Experimental/Investigational based on the above criteria.

Extended Care Facility means an institution operating pursuant to applicable laws that is engaged in providing, for a fee, inpatient skilled nursing care and related services under the supervision of a Physician and Registered Nurses. It must have facilities for 10 or more inpatients and maintain medical records of all its patients.

He, His and Him includes "she", "her" and "hers."

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

Hospital means an institution licensed, accredited or certified by the State that:

1. Operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons;
2. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
3. Provides 24-hour nursing service by registered nurses (R.N.) on duty or call;
4. Has a staff of one or more licensed Physicians available at all times;
5. Provides organized facilities for diagnosis, treatment and surgery, either
    a. on its premises; or
    b. in facilities available to it, on a pre-arranged basis;
6. Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
7. Is not a place for the long-term treatment of drug addiction, alcoholism, or the Custodial Care.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.
We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

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

In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Eligible Expense under the Policy.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or Substance Abuse, except as specifically stated.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

Immediate Family means a Plan Participant’s spouse, domestic partner, Civil Union Partner, parent (includes Step-parent), child(ren) (includes legally adopted or step child(ren), brother, sister, step-child(ren), grandchild(ren), or in-laws).

Injury means bodily harm which results independently of disease or bodily infirmity, from an Accident after the effective date of a Plan Participant’s coverage under the Policy, while the Policy is in force as to the person whose Injury is the basis of the claim. All injuries to the same Plan Participant sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

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

Insurance means the coverage that is provided under the Policy.

Intensive Care Unit means a cardiac care unit or other unit or area of a Hospital which meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Intoxicated means a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Plan Participant is located at the time of an incident.

Maximum Benefit means the largest total amount of Eligible Expenses that the Company will pay for the Plan Participant as shown in the Plan Participant's Schedule of Benefits.

Medical Treatment means any and all medical care, treatment, services, supplies, procedures, or drugs that may administered to a Plan Participant to address a sickness or injury.

Medically Necessary means a treatment, drug, device, service, procedure or supply that is:

1. Required, necessary and appropriate for the diagnosis or treatment of an Injury or Sickness;
2. Prescribed or ordered by a Physician or furnished by a Hospital;
3. Performed in the least costly setting required by the condition;
4. Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

The purchasing or renting air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them, and general exercise equipment are not considered Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may consider the cost of the alternative to be the Eligible Expense.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental/Investigational or for research purposes;
- Is provided for education purposes or the convenience of the Plan Participant, the Plan Participant's family, Physician, Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the person's condition or the quality of medical care;
- Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
- Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- It can be safely provided to the patient on a less cost effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.

Mental or Nervous Disorder means any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the medical care or treatment is rendered to a Plan Participant.

Natural Teeth means the major portion of the individual tooth which is present, regardless of filings and caps; and is not carious, abscessed, or defective.

Network Provider means a Physician, Hospital and other healthcare providers who have contracted to provide specific medical care at negotiated prices.

The availability of specific providers is subject to change without notice. You should always confirm that a Network Provider is participating at the time services are required by visiting the PPO's find a doctor site at https://hcpdirectory.cigna.com/web/public/providers and/or by asking the provider when you make an appointment for services.

Non-Network Provider means a Physician, Hospital and other healthcare providers who have not agreed to any pre-arranged fee schedules. A Plan Participant may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Plan Participant's responsibility.

Outpatient means a Plan Participant who receives care in a Hospital or another institution, including; ambulatory surgical center; convalescent/ Skilled Nursing Facility; or Physician's office, for an Injury or Sickness, but who is not confined and is not charged for room and board.

Out-of-Pocket Maximum means the maximum dollar amount the Plan Participant is responsible to pay during a Policy Term. After the Plan Participant has reached the Out-of-Pocket Maximum, the Policy pays 100% of Eligible Expenses for the remainder of the Policy Term. The Out-of-Pocket Maximum is met by the payment of accumulated Deductible, Coinsurance and Co-payments. Penalties and amounts above the Preferred Allowance or Usual, Reasonable and Customary Expenses do not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is shown on the Schedule of Benefits.

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

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

Physician means a legally licensed practitioner of the healing arts who is practicing within the scope of his or her license while performing a particular service which is covered under the Policy. Physician does not include:

- a practitioner of chiropractic or alternative medicine;
- any Plan Participant;
- a Close Relative of a Plan Participant; or
- an individual residing at the same legal residence of the Plan Participant .

Physical Therapy means any form of the following administered by a Physician: (1) physical or mechanical therapy; (2) diathermy, (3) ultra-sonic therapy; (4) heat treatment in any form; or (5) manipulation or massage.

Plan Participant means a Person eligible for coverage as identified in the Enrollment/Application as a Non-United States Citizen traveling outside their Home Country and has his or her true, fixed and permanent home and principal establishment outside of the United States and holds a current and valid passport, for whom proper premium payment has been made when due, and who is therefore a Plan Participant under the Policy.

Policy means this document, the Application of the Policyholder and the Participating Organization and any end endorsements, riders or amendments that will attach during the Period of Coverage.

Policy Period means the period of time following the Policy's Effective Date, as shown on the Schedule of Benefits.

Policyholder means the entity shown as the Policyholder in the Schedule of Benefits.

Preferred Allowance means the amount a Network Provider will accept as payment in full for Eligible Expenses.

Pre-Existing Condition means an Injury, Sickness, disease, or other condition during the 6 month period immediately prior to the date the Plan Participant's coverage is effective for which the plan participant:

1. received or received a recommendation for a test, examination or Medical Treatment for a condition which first manifested itself, worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment;
2. Took or received a prescription for drugs or medicine.

Item (2) of this definition does not apply to a condition which is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the 6 months period before coverage is effective under the Plan Participant's Plan.

A pregnancy which originated prior to the Plan Participant's Effective Date of Coverage under the Policy is considered a Pre-Existing Condition.

Pregnancy means the physical condition of being pregnant, including Complications of Pregnancy.

Prescription Drugs means drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the Food and Drug Administration.

Registered Nurse means a licensed registered professional Registered Nurse (R.N.).

Service Provider means a Hospital, convalescent/ Skilled Nursing Facility, ambulatory surgical center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, alcohol or drug dependency treatment center, birthing center, Physician, Dentist, chiropractor, licensed medical practitioner, Registered Nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility that the Company approves.

Sickness means Sickness or disease contracted and causing loss commencing while the Policy is in force as to the Plan Participant whose Sickness is the basis of claim. Any complication or any condition arising out of a Sickness for which the Plan Participant is being treated or has received Treatment will be considered as part of the original Sickness.

Skilled Nursing Facility means a facility that provides skilled nursing 24 hours a day, seven days a week, under the supervision of a Registered Nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A Skilled Nursing Facility provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge.

Spouse means lawful spouse, if not legally separated or divorced, or domestic partner or Civil Union Partner.

Student Health Center means an ambulatory care facility affiliated or contracted with a Participating School that, at a minimum, maintains a staff consisting of a nurse director/nurse practitioner and/or staff Nurses, and may have either a staff Physician or an arrangement with a Physician to perform office visits. In the event a Participating School does not otherwise have a Student Health Center, the Participating School may request permission from the Program Manager to designate a Walk-In Pharmacy Clinic to be treated as a Student Health Center for the purposes of the policy.

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

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

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

Usual, Reasonable and Customary (URC) means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred. The most common charge means the lesser of:

- The actual amount charged by the provider;
- The negotiated rate; or
- The charge which would have been made by the provider (Physician, Hospital, etc) for a comparable service or supply made by other providers in the same Geographic Area, as reasonable determined by Us for the same service or supply.

"Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Usual, Reasonable and Customary Charges, Fees or Expenses as used in the Policy to describe expense will be considered to mean the percentile of the payment system in effect at Policy issue as shown on the Schedule of Benefits.

Utilization of Nuclear, Chemical or Biological weapons of mass destruction shall mean the use of:

- any explosive nuclear weapon or device; or
- the emission, discharge, dispersal, release or escape of:
- fissile material emitting a level of radioactivity, or
- any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins), or
- any solid, liquid or gaseous chemical compound which, when suitably distributed
- which is capable of causing incapacitating disablement or death amongst people or animals.

Walk-In Pharmacy Clinic means a clinic which is set-up inside a larger retail operations, such as a pharmacy or retail store, and which provides basic care for minor injuries and illnesses, and may provide vaccinations, immunizations, annual physicals, health screenings, and diagnostics tests.

We, Our, Us means Brit Syndicates Limited on behalf of Syndicate 2987 at Lloyd’s.

You, Your, Yours, He or She means the Plan Participant who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.

ELIGIBILITY FOR INSURANCE

Persons eligible to be a Plan Participant under the Policy are those persons described as an ELIGIBLE CLASS on the Application and Schedule of Benefits. This includes anyone who may become eligible while the Policy is in force.

We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

The Plan Participant must be engaged in Full-Time Studies and must actively attend classes for at least the first 31 days after the date for which coverage is purchased **Full-Time Studies** means the enrollment and active participation in at least the minimum number of credit hours in which an international student must be enrolled and actively attending classes in the United States per the terms of the applicable student visa. Full-Time Studies includes participation in no more than one online or television course per term; any online or television coursework in excess of one course per term does not count toward fulfilling the full-time status requirement for eligibility. Home study and correspondence courses do not count toward fulfilling the full-time status requirement for eligibility. We maintain the right to investigate student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever we discover that the policy eligibility requirements have not been met, our only obligation is refund of premium.

This insurance is not subject to, and will not be administered as a PPACA (Patient Protection and Affordable Care Act) insurance plan. PPACA requires certain U.S. residents and citizens obtain PPACA compliant insurance coverage. This plan is not designed to cover U.S. residents and citizens. This policy is not subject to guaranteed issuance or renewal.

EFFECTIVE DATES OF INSURANCE:

Policy Effective Date. The Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder and will continue in force until either a) the Policy Expiration Date stated in the Schedule; or b) the Policy is cancelled pursuant to the terms of the Policy.

Plan Participant's Effective Date for all other Coverages:

A person will become a Plan Participant under the Policy, provided proper premium payment is made, on the latest of:

1. The Effective Date of the Policy; or
2. The date the Company receives a completed application or enrollment form; or
3. The day the Plan Participant becomes eligible, subject to any required waiting period, according to the referenced date requested and shown in the Application/Enrollment Form and Schedule of Benefits; or
4. The Date the Company approves the Application; or
5. The Date requested by the Participating Organization.

TERMINATION DATE OF INSURANCE:

Policy Termination Date

Termination takes effect at 11:59 P.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

The Policy terminates automatically on the earlier of:

1. The Policy Expiration Date shown in the Policy; or
2. The premium due date if premiums are not paid when due, subject to any grace period.

Failure by the Participating Organization to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate the Policy on the last day of the period for which premiums have been paid.

The Policy may be terminated by the Policyholder or the Company as of any premium due date by giving written notice to the other and the Participating Organization at least 31 days prior to such date.

The Policyholder and the Company may terminate the Policy at any time by written mutual consent.

If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.

Plan Participant's Termination Date for all other Coverages:

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

1. The date the Plan Participant is no longer in an Eligible Class;
2. The date the Plan Participant returns to the Plan Participant's Home Country;
3. The date shown on the Schedule of Benefits or Evidence of Coverage issued by the Company;
4. The date the Plan Participant becomes a permanent resident of the United States;
5. The date the Plan Participant reports for full-time active duty in any Armed Forces. Upon receipt of proof of service, We will refund any premium paid, calculated from the date active duty begins until the earlier of:
    a. The date the premium is fully earned; or
    b. The Expiration Date of the Policy;
6. The end of the period for which the last premium contribution is made;
7. The date the Policy is terminated;
8. The date the Participating Organization requests, in writing, that Plan Participant's coverage be terminated;
9. The date the Plan Participant's participation in the Program terminates;
10. The date the Participating Organization is no longer eligible to offer or sponsor coverage under the Policy; or
11. The expiration date of the term of coverage, requested by the Participating Organization.

PREMIUM PROVISIONS

Premiums:

The Company provides insurance in return for premium payments. The premium shown in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium due dates are the first of every month unless otherwise stated in the Policy. Premium payment made in advance or for more than a one month period will not affect any provisions of the Policy with regard to change. Premiums due for the Policy will be remitted to Us by the Participating Organization or by any other person designated by the Participating Organization to remit such premiums.

Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

Grace Period

A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period provided the Participating Organization pays all the premiums due by the last day of the grace period, unless notice has been sent, in accordance with the TERMINATION provision, of the intent to terminate coverage under the Policy. Coverage will end if the premium is not paid by the end of the grace period.

Changes in Premium Rate

The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. Notice will be sent to the Participating Organization's most recent address in Our records.

No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates immediately at any time if any of the following events occur:

1. A change in the terms of the Policy.
2. A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy.
3. A change in the factors bearing on the risk assumed.
4. A misrepresentation in the information relied on in establishing the rate for the Policy

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

Reinstatement

The Policy may be reinstated within 31 days of lapse if it is lapsed for nonpayment of premium, if the Participating Organization submits written application to the Company, the Company accepts the application and the Participating Organization makes payment of all overdue premiums.

SCOPE OF COVERAGE

Benefits are payable under the Policy for Eligible Expenses incurred by a Plan Participant for the items stated in the, Schedule of Benefits. Benefits will be payable to either the Plan Participant or the Service Provider for Eligible Expenses incurred outside the Plan Participant's Home Country.

The charges enumerated herein will in no event include any amount of such charges which are in excess of Preferred Allowance or Usual, Reasonable and Customary charges. If the charge incurred is in excess of such average charge such excess amount will not be recognized as an Eligible Expense. All charges will be deemed to be incurred on the date such services or supplies, which give rise to the expense or charge, are rendered or obtained.

We will provide the benefits described in the Policy to all Plan Participants who suffer a Covered Loss which:

1. Is within the scope of the **DESCRIPTION OF BENEFITS** provisions; and
2. Occurs while the person is a Plan Participant under the Policy.

Terms of Payment for Benefits:

Primary Medical Expense:

If an Injury or Sickness to the Plan Participant results in his incurring Eligible Expenses for any of the services on the Schedule of Benefits, We will pay the applicable benefit, subject to any applicable Co-Payment and Coinsurance Percentage.

The Plan Participant must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for treatment of a covered Injury or Sickness:

1. While the person is a Plan Participant under the Policy; or
2. During the Policy Period stated on the Schedule of Benefits.

Such benefits will be paid on a primary basis, regardless of any other coverage the Plan Participant may have.

The first Eligible Expense must be incurred within the time frame stated on the Schedule of Benefits.

The total of all medical benefits payable under the Policy is shown on the Schedule of Benefits and is subject to the specific maximums shown on the Schedule of Benefits.

Coordination of Benefits Provision:

If a Plan Participant is covered for Benefits under the Policy, and is also covered for these Benefits under one or more other Plans, the benefits payable under the Policy will be coordinated with the benefits payable under all other Plans.

Coordination of Benefits will be used to determine the benefits payable for a Plan Participant for any Claim Determination Period if, for the Allowable Expenses incurred in that period, the sum of (1) and (2) below would exceed those Allowable Expenses:

1. The benefits that would be payable under the Policy without coordination; and
2. The benefits that would be payable under all other Plans without the coordination of benefits provisions in those Plans.

The benefits that would be payable under the Policy for Allowable Expenses incurred in any Claim Determination Period without Coordination of Benefits will be reduced to the extent required so that the sum of:

1. Those required benefits; and

2. All the benefits payable for those Allowable Expenses from all other Plans will not exceed the total of those Allowable Expenses.

Benefits payable under all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of the Policy are determined if:

1. The Benefit Determination Rules would require the Policy to determine its benefits before that Plan; and
2. The other Plan has a provision that coordinates its benefits with those of the Policy and would, based on its rules, determine its benefits after the Policy.

When Coordination of Benefits reduces the total amount otherwise payable in a Claim Determination Period for a Plan Participant, each benefit that would be payable in the absence of Coordination of Benefits will be reduced in proportion. The reduced amount will be charged against any applicable benefit limit of the Policy.

We reserve the right to release to or obtain from any other insurance company or other organization or person, any information that, in Our opinion, We or it needs for the purpose of the Coordination of Benefits.

When payments that should have been made under the Policy based on the terms of this provision have been made under any other Plans, We have the right to pay to any other organization making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered benefits paid under the Policy. We will be released from all liability under the Policy to the extent of these payments. When an overpayment has been made by us, at any time, We will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance company or organization, as We may determine.

Benefit Determination Rules - The rules below establish the order in which benefits will be determined:

1. **Benefits not as a Dependent:** The benefits of a Plan that covers the person for whom claim is made other than as a dependent will be determined before a Plan that covers that person as a dependent.
2. **Dependent Benefits under Different Parent Plans:** The benefits of a Plan that covers the person for whom claim is made as a dependent of the parent whose birthday falls earlier in the year will be determined before the benefits that covers that person as a dependent under the other parent's Plan.

   When both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

   However, if the other Plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

   Notwithstanding the foregoing, in the case of a dependent child of divorced or separated parents, the following rules will apply:

   a. If there is a court decree that establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan that covers the child as a dependent of the parent so responsible will be determined before any other Plan, otherwise:

   b. The benefits of a Plan that covers the child as a dependent of the parent with custody will be determined before a Plan that covers the child as a dependent of a step-parent or a parent without custody;

c. The benefits of a Plan that covers the child as a dependent of a step-parent will be determined before a Plan that covers the child as a dependent of the parent without custody.

3. **Benefits for Person Longest Covered:** When the above rules do not establish the order, the benefits of a Plan that has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time.

Right to Receive and Release Necessary Information
For this section to work, We must exchange information with other plans. To do so, We may give to or get from any source all such information necessary. This will be done without the consent of or notice to any person. Any people claiming Benefits under this plan must give to Us the required information.

Facility of Payment
Another Plan may pay a Benefit that should be paid by Us by terms of this section. If this happens, We may pay to such payor the amount required for it to satisfy the intent of this section. Any amount so paid will be considered a Benefit under this plan. We will not be liable for such payment after it is made.
Whenever used in this provision:

Plan means any plan which provides Benefits or services for, or by reason of, Hospital, surgical, medical, or dental care, or treatment through:

1. Group, blanket or franchise insurance coverage;
2. Service plan contracts, group or individual practice or other prepayment plans;
3. Coverage under any labor management trusteed Plans, union welfare plans, employer organization plans, professional organizations, self-funded plans or employee benefit organization plans which provides medical or dental benefits or services; or
4. A government program, or statue, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;
5. Medicare (Title XVIII of the Social Security Act); and
6. Any part of a state auto reparation or indemnity act (no-fault insurance) with which the state permits coordination.

Plan does not include coverage under individual or family policies or contracts. Each Plan or part of a Plan that has a right to coordinate benefits will be considered a separate Plan.

This Plan means the medical care Benefits provided by the Policy.

Allowable Expense means any necessary, Usual, Reasonable and Customary item of expense, incurred while the person (for whom the claim is made) is Plan Participant, or is entitled to Benefits after insurance ends, under the Policy; and at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under the Policy.

DESCRIPTION OF BENEFITS

ACCIDENT AND SICKNESS BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT

If, within 90 days from the date of an Accident or Injury covered by the Policy, the Plan Participant suffers from a Covered Loss, We will pay the percentage of the Principal Sum set opposite the loss in the table below. If the Plan Participant sustains more than one such Loss as the result of one Accident, We will pay only one amount, the largest to which he is entitled. This amount will not exceed the Principal Sum which applies for the Plan Participant. The Principal Sum is the Maximum Benefit Amount shown in Schedule of Benefit.

Benefits are payable if such Injury occurs during the course of time the Plan Participant is covered under the Policy.

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS

We will pay Accident and Sickness Medical Expense Benefits for Eligible Expenses. These benefits are subject to the Co-Payment, Coinsurance Factors, Policy Period, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident and Sickness Medical Expense Benefits are only payable:

1. for the Preferred Allowance or Usual, Reasonable and Customary Charges incurred after the Copay has been met;
2. for those Medically Necessary Eligible Expenses incurred by or on behalf of the Plan Participant;
3. for Eligible Expenses incurred within 365 days after the date of the Eligible Expense.

No benefits will be paid for any expenses incurred that are in excess of the Preferred Allowance or Usual, Reasonable and Customary Charges.

Eligible Medical Expenses include the following expenses as further indicated in the Schedule of Benefits or elsewhere in this policy:

1. **Medical Treatment:** For the diagnosis and medical Treatment by a Physician or a Registered Nurse.
2. **Hospital Admission Expenses:** Charges for each hospital admission.
3. **Outpatient Pre-Surgical Testing benefit** – charges for Pre-surgical testing.
4. **Nursing Services** – Outpatient Charges for nursing services by a Registered Nurse or Licensed Professional.
5. **Skilled Nursing Facility** - charges for services as described in the schedule of benefits. The benefit provides skilled nursing 24 hours a day, seven days a week, under the supervision of a registered nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A SNF provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence.

   A SNF confinement must take place within 14 days from a hospital discharge and must represent care for the same condition which required hospitalization that lasted a minimum of three days. Care may not be custodial in nature (e.g., care which could be performed at home). The facility may not be primarily a place which provides general care for the aged.

6. **Hospice Care Benefit** - charges for a maximum of 14 days of:

   a. nursing care by a Registered Nurse; or a licensed practical Registered Nurse, a vocational Registered Nurse, or a public health Registered Nurse who is under the direct supervision of a Registered Nurse;
   b. physical therapy and speech therapy when rendered by a licensed therapist;
   c. medical supplies, including drugs and the use of medical appliances;
   d. physician's services; and
   e. services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.
7. Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.
8. Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items.
9. Diabetes Coverage that includes medical supplies, equipment and education for diabetes care for all diabetics.

ADDITIONAL BENEFITS

HOSPITAL ROOM & BOARD BENEFIT

We will pay charges for the **Average Semiprivate Charge** for each day of the Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule. In computing the number of days payable under this benefit, the date of admission will be counted. Hospital Room and Board expenses will include floor nursing while confined in a ward or semi-private room of a Hospital and other Hospital services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's average charge for semiprivate room and board accommodation.

INTENSIVE CARE UNIT BENEFIT

We will pay charges for each day of Intensive Care Unit confinement, up to the Daily Maximum Benefit shown in the Schedule of Benefits. This payment is in lieu of payment for the Hospital Room and Board charges for those days and includes nursing services.

HOSPITAL MISCELLANEOUS EXPENSE BENEFIT

We will pay for services, supplies and charges during a Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule per day. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies; and blood and blood transfusions. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

SURGEON (IN OR OUTPATIENT) BENEFITS

We will pa**y** charges for:

1. A Physician, for primary performance of a surgical procedure, up to the Maximum Benefit Amount shown in the Schedule of Benefits per procedure.
2. A Physician, for assistant surgeon duties up to the Maximum Benefit shown in the Schedule of Benefits.

ASSISTANT SURGEON BENEFIT

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

PRE-ADMISSION TESTING BENEFIT

We will pay benefits for charges for Pre-admission testing.

ANESTHESIA BENEFIT

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

DAY SURGERY MISCELLANEOUS BENEFIT

We will pay Day Surgery Miscellaneous benefits for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs or medicine; therapeutic services; and supplies, on an outpatient basis.

DIAGNOSTIC X-RAY AND LABORATORY BENEFIT

We will pay the benefit if the Plan Participant requires diagnostic x-ray and/or laboratory examinations and services due to a Covered Loss, up to the Maximum Benefit per covered Injury or Sickness indicated in the Schedule of Benefits. Outpatient x-ray services and laboratory tests are limited to the amount shown in the Schedule of Benefits.

AMBULANCE BENEFIT

When, by reason of Injury or Sickness, a Plan Participant requires the use of a community or Hospital Ambulance in a Medical Emergency, We will pay a Benefit Amount up to a Maximum shown in the schedule (if any), within the metropolitan area in which the Plan Participant is located at that time the service is used. Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, the scene of the Accident or Medical Emergency to a Hospital or between Hospitals. Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area.

Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness or if the Plan Participant is in a rural area, then air ambulance transportation to the nearest metropolitan area will be considered a Eligible Expense. Air Ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

PHYSICIAN VISIT BENEFIT (INPATIENT)

We will pay charges by a Physician for other than pre- or post-operative care for in-Hospital visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.

PHYSICIAN VISIT BENEFIT (OUTPATIENT)

We will pay charges by a Physician for office visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Office Visits.

CONSULTANT PHYSICIAN BENEFIT

If, by reason of Injury or Sickness, a Plan Participant requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending Physician for the purpose of confirming or determining a diagnosis, We will pay the Covered Percentage of the Covered Expenses incurred.

RADIATION/ CHEMOTHERAPY THERAPY EXPENSE BENEFIT

We will pay the Covered Percentage for the Covered Expenses incurred by a Plan Participant for drugs used in antineoplastic therapy and the cost of its administration. Coverage is provided for any drug approved by the Federal

Food and Drug Administration (FDA), regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug was approved by the FDA, so long as:

1. the drug is ordered by a Physician for the treatment of a specific type of neoplasm;
2. the drug is approved by the FDA for use in antineoplastic therapy;
3. the drug is used as part of an antineoplastic drug regimen;
4. current medical literature substantiates its efficacy, and recognized oncology organizations generally accept the treatment; and
5. the Physician has obtained informed consent from the patient for the treatment regimen that includes FDA approved drugs for off-label indications.

INFUSION THERAPY

We will pay the Covered Expenses for infusion therapy prescribed and administered by a licensed Physician.

RENAL DIALYSIS/HEMODIALYSIS

We will pay the Covered Expenses for Renal Dialysis/Hemodialysis prescribed and administered by a Physician.

POST-MASTECTOMY COVERAGE

We will pay the Covered Expenses for a Medical Necessary mastectomy which may also include coverage of the following:

a. physical complications during any stage of the mastectomy, including lymphedemas;
b. reconstruction of the breast;
c. surgery on the non-diseased breast to attain the appearance of symmetry between the two breasts; and
d. two external breast prostheses.

Covered Expenses for the above are payable on the same basis as Covered Expenses for any other surgery. This coverage will be provided in consultation with the attending Physician and the patient.

EMERGENCY ROOM BENEFIT

We will pay this benefit if the Plan Participant requires Emergency Room treatment due to a Covered Loss resulting directly and independently of all other causes from a covered Injury or Sickness.

Emergency Room means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.

Services including physician charges and related x-ray/laboratory interpretations will be paid under this benefit.

SELF-INFLICTED INJURY BENEFIT

For charges related to Medical Treatment required as the result of an intentionally self-inflicted injury or sickness, suicide, or attempted suicide, while sane or insane.

ALLERGY TREATMENT

We will pay for Covered Expenses for Medically Necessary treatment of allergies, as diagnosed and prescribed by a Physician.

WELLNESS MEDICAL EXPENSE BENEFIT:

Wellness Benefit. For any combination of the following: routine physical or health examinations, sports physicals, gynecologic health screenings, routine baseline or screening mammograms, prostate and/or colorectal examinations and related laboratory tests, annual health checkups, immunizations indicated on the Recommended Immunization Schedule by the Centers for Disease Control and Prevention, and tuberculosis tests.

MATERNITY AND PRE-NATAL CARE BENEFIT

When a covered Maternity is incurred by a Plan Participant, the Company will pay the Preferred Allowance or Usual, Reasonable and Customary medical expenses in excess of the Coinsurance as stated in the Schedule of Benefits, Maternity. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits Maternity, as to Eligible Expenses during any one period of individual coverage.

Benefits will be payable for Eligible Expenses an Plan Participant incurs before, during, and after delivery of a child, including Physician, Hospital, laboratory, and two ultrasound services. Coverage for the Inpatient postpartum stay for the Plan Participant and her newborn child in a Hospital, will, at a minimum, be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their guidelines for Perinatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the Plan Participant Person's attending Physician determines further Inpatient postpartum care in not necessary for the Plan Participant or her newborn child provided that in the opinion of the Plan Participant Person's attending Physician, the newborn child meets the criteria for medical stability in the guidelines for Perinatal Care prepared by the Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of:

1. The antepartum, intrapartum, postpartum course of the mother and infant;
2. The gestational stage, birth weight, and clinical condition of the infant;
3. The demonstrated ability of the mother to care for the infant after discharge; and
4. The availability of post discharge follow up to verify the condition of the infant after discharge.

Newborn – Sick Baby Care

A newborn child of a Plan Participant will automatically be considered eligible for Sick Baby Care for a period not to exceed 30 days and up to a maximum benefit of $50,000 for conditions which are due directly to a covered Injury or Sickness, premature birth, or birth abnormalities which exist at birth.

A newborn child of a Plan Participant will be eligible to receive the following services:

1. Hospital room and board (or nursery) charges,
2. routine Physician visits while Hospital confined; and
3. circumcision while Hospital confined.

EMERGENCY DENTAL EXPENSE BENEFIT

We will pay benefits as described in the Schedule of Benefits for expenses for emergency dental treatment due to Injury to Natural Teeth. We will pay benefits as described in the Schedule of Benefits for expenses incurred during the Plan Participant's trip for emergency dental treatment. Only expenses for emergency dental treatment to Natural Teeth incurred during the trip will be reimbursed. Expenses incurred after the trip are not covered.

PHYSIOTHERAPY EXPENSE BENEFIT

We will pay benefits as described in the Schedule of Benefits for eligible Physiotherapy expenses incurred by the Plan Participant. We will pay Preferred Allowance or Usual, Reasonable and Customary expenses as stated in the Schedule of Benefits. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Expenses during any one period of individual coverage.

For the purpose of this section, **Physiotherapy** means charges for physiotherapy if recommended by a Physician for the treatment of a specific Injury or Sickness or following hospitalization and administered by a licensed physiotherapist as an outpatient, up to up to the maximum amount shown in the Schedule of Benefits per day for the Outpatient Physiotherapy benefit.

Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic, acupuncture, or any form of physical therapy. Physiotherapy expenses do not include massage therapy services unless performed by a licensed physical therapist or chiropractor who is operating within the scope of his or her license.

DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, a Plan Participant requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Eligible Expenses incurred by a Plan Participant for such Durable Medical Equipment. We pay the Covered Percentage of the Eligible Expenses incurred by a Plan Participant for the purchase or rental of such item. In no event shall we pay rental charges in excess of the purchase price. Any rental charges paid will be applied toward the cost of the purchase price if the equipment is purchased at a later date.
We do not pay for the replacement of Durable Medical Equipment.

Durable Medical Equipment means medical equipment that:

1. is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
2. can withstand long-term repeated use without replacement;
3. is not useful in the absence of an Injury or Sickness; and
4. can be used in the home without medical supervision.

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses, subject to the Coinsurance Percentage shown in the Schedule of Benefits, if any; for a Prescription Drug or medication when prescribed by a Physician on an outpatient basis.

Prescription Drug means a drug which:

1. Under Federal law may only be dispensed by written prescription; and
2. Is utilized for the specific purpose approved for general use by the Food and Drug Administration.

The Prescription Drug must be dispensed for the outpatient use by the Plan Participant:

1. On or after the Plan Participant's Effective Date; and
2. By a licensed pharmacy provider.

This benefit includes injectable drugs and other drugs administered in a Physician's office or other outpatient setting.

EXTENSION OF ACCIDENT AND SICKNESS MEDICAL BENEFITS

Continuation Benefits: For Covered Expenses incurred, while Hospital confined, as indicated in the Schedule of Benefits for a covered Injury or Covered Sickness for which a Plan Participant has a continuing claim on the date his or her coverage terminates. Benefits payable under this provision will terminate if a Plan Participant becomes covered, for the covered Injury or Sickness for which benefits were continued, under any other medical coverage.

MENTAL OR NERVOUS DISORDER EXPENSE BENEFIT

If a Plan Participant requires treatment for a Mental or Nervous Disorder, We will pay for such treatment as follows:

BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT

When a Plan Participant requires Hospital Confinement for treatment of a Mental or Nervous Disorder, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement as set forth in the Schedule of Benefits.

Such confinement must be in a licensed or certified facility, including Hospitals.

BENEFITS FOR OUTPATIENT SERVICES

We will pay the Covered Percentage of the Eligible Expenses incurred for the outpatient treatment of Mental or Nervous Disorder as defined up to one visit per day.

The Mental or Nervous Disorder must, in the professional judgment of healthcare providers, be treatable, and the treatment must be Medically Necessary.

Outpatient treatment and Physician services include charges made by an outpatient treatment department of a Hospital, or community mental health facility, or charges for services rendered in a Physician's office. Treatment may be provided by any properly licensed Physician, psychologist or other provider as required by law.

Biologically Based Mental Sickness means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Sickness.

We will pay the Covered Percentage of the Eligible Expenses incurred for treatment of biologically based mental Sickness, including but not limited to:

1. Schizophrenia;
2. Schizoaffective disorder;
3. bipolar affective disorder;
4. major depressive disorder;
5. specific obsessive-compulsive disorder;
6. delusional disorders;
7. obsessive compulsive disorders;
8. anorexia and bulimia; and
9. panic disorder.

ALCOHOL AND DRUG ABUSE EXPENSE BENEFIT

If a Plan Participant requires treatment on account of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay for such treatment as follows:

BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT

When a Plan Participant is confined as an inpatient in: (i) a Hospital; or (ii) a Detoxification Facility for the treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement.

Such Confinement must be in a licensed or certified facility, including Hospitals.

BENEFITS FOR OUTPATIENT SERVICES

We will pay the Covered Percentage of the Eligible Expenses incurred for the treatment of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency.

Outpatient Treatment and Physician services include charges for services rendered in a Physician's office or by an outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the Hospital, community mental health facility or alcoholism treatment facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health.

Alcohol Abuse means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Drug Abuse means a condition that is characterized by a pattern of pathological use of a drug with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Detoxification Facility means a facility that provides direct or indirect services to an acutely Intoxicated individual to fulfill the physical, social and emotional needs of the individual by:

a) monitoring the amount of alcohol and other toxic agents in the body of the individual;
b) managing withdrawal symptoms; and
c) motivating the individual to participate in the appropriate addictions treatment programs for Alcohol and Drug Abuse.

EMERGENCY MEDICAL EVACUATION, MEDICAL REPATRIATION AND RETURN OF REMAINS

Medical Evacuation Benefit: Subject to prior approval from the Program Manager or its authorized representative, for reasonable expenses related to the air evacuation of an injured or sick Plan Participant (and a Health Care Provider or Escort if such is directed by the attending Physician) to the Plan Participant's home country or country of regular domicile, provided the air evacuation:

1. is upon the attending Physician's written certification;
2. results from a covered Injury or Sickness; and
3. **does not occur prior to the benefit approval.**

Repatriation Benefit: Subject to prior approval from the Program Manager or its authorized representative, for reasonable expenses incurred in connection with the preparation and transportation of the body of a deceased Plan Participant to his or her place of residence in his or her home country. This benefit does not include transportation expenses of any person accompanying the body.

EXCEPTIONS AND EXCLUSIONS

Unless specifically provided for elsewhere under the Policy, the Plan does not provide benefits, nor is any premium charged, for any Medical Treatment not expressly indicated in the Covered Expense section.

For further clarity, please note that the Plan does not provide benefits, nor is any premium charged, for:

1. Medical Treatment for which benefits are excluded, excepted, or limited elsewhere in this Policy;
2. Medical Treatment received by the Plan Participant in his or her home country or country of regular domicile;
3. Medical Treatment received due to a Pre-Existing Condition or complication thereof in excess of benefits provided elsewhere in this coverage. Medical Treatment for Pre-Existing Conditions will be payable under the Policy after the Plan Participant's coverage has been in force for three consecutive months. However, a pregnancy which originated prior to the Plan Participant's Effective Date of Coverage will not be covered under the Policy.
4. Medical Treatment which is not Medically Necessary, as defined in the Policy;
5. Medical Treatment for which no charge is made or for which no payment would be required if the Plan Participant did not have this insurance; or to the extent the Plan Participant received any discount, credit, or reduction due to an agreement with the provider;
6. Medical Treatment normally provided without charge by an Immediate Family member of the Plan Participant or by employees or Physicians employed by, under contract with, or retained by the Participating School, unless provided in a Student Health Center by its employees;
7. Medical Treatment required for any covered Injury or Sickness which occurs while the Plan Participant is employed with the Participating School in any capacity, whether paid or unpaid; or to the extent such covered Injury or Sickness is covered under: any occupational benefit plan; any Worker's Compensation or similar law; or any medical payments under individual automobile insurance (except for no-fault auto insurance);
8. Charges which are in excess of Preferred Allowance or Usual, Reasonable and Customary charges whichever applies;
9. Hearing aids, eye glasses, or contact lenses and the fitting or servicing thereof, except that the Policy will cover these expenses if the need for such results directly from an Injury or covered eye surgery;
10. Birth control devices and surgical procedures;
11. Elective or preventive surgery or any Medical Treatment related to an elective or preventive surgery including, but in no way limited to, tubal ligation, vasectomy, breast reduction or enlargement, abortion (except spontaneous and non-elective abortion), circumcision (except as may be provided under Newborn – Sick Baby Care), Immunizations (except as listed in Covered Expenses), immunization antibody testing, allergy tests, vitamins, and antitoxins; or the correction or treatment of a deviated septum;
12. Cosmetic, plastic, reconstructive, or restorative surgery unless such are Covered Expenses incurred for repair of a disfigurement caused from:
    a. a covered Injury;
    b. a birth defect of an dependent born while the mother was insured under this Policy; or
    c. a mastectomy (refer to the Post-Mastectomy Coverage provision);
13. Medical Treatment related to organ transplants, whether as donor or recipient; this includes expenses incurred for the evaluation process, the transplant surgery, post operative treatment, and expenses incurred in obtaining, storing or transporting a donor organ. In relation to a bone marrow or stem cell transplant this exclusion would include harvesting & mobilization charges.

14. Medical Treatment for injuries sustained in practice for or participation in professional sports; or in practice for or participation in interscholastic or intercollegiate sports in excess of benefits provided elsewhere in this coverage, if any;
15. War or any act of war, declared or undeclared or the Commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal occupation; or the Voluntary, active participation in a civil war, riot, rebellion, insurrection, or revolution;
16. Medical treatment arising out of aeronautics or air travel, except while riding as a passenger on a regularly scheduled commercial airline, in excess of benefits provided elsewhere in the coverage, if any;
17. Suicide, attempted suicide (including drug overdose) self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane in excess of benefits provided elsewhere in the coverage, if any;
18. Medical Treatment received in connection with the teeth, gums, jaw, or structures directly supporting the teeth; myofascial pain; or temporomandibular joint dysfunction in excess of benefits provided elsewhere in the coverage, if any;
19. Medical Treatment for Injuries sustained while participating in hazardous or adventure sports of any kind, including but not limited to hoverboard usage, hang gliding, skydiving, parachuting, vehicle racing of any kind, any rodeo activity, BASE jumping, kiteboarding, mountaineering or climbing or trekking above elevation 4500 meters above ground level or without proper equipment or guides, luge, motocross, Moto-X, ski jumping, off-piste or off-trail skiing or snowboarding, sub-aquatic activities below 50 meters, whitewater rafting exceeding Class IV difficulty;
20. Medical Treatment for injury or sickness sustained by reason of a motor vehicle or motorcycle accident
    - to the extent that benefits are paid or payable by any other valid and collectible insurance whether or not claim is made for such benefits,
    - if the Plan Participant was operating the motor vehicle or motorcycle while Intoxicated under the laws of the state in which the accident occurred,
    - if the Plan Participant was operating the motor vehicle or motorcycle without a driver's license or permit recognized as valid under the laws of the state in which the accident occurred, or
    - if the Plan Participant was not operating the motor vehicle or motorcycle in conformity with the restrictions of the driver's license or permit;
21. Medical Treatment for an Injury or Sickness resulting from the Plan Participant's intoxication or use of illegal drugs or any drugs or medication that is intentionally not taken in the dosage recommended by the manufacturer or for the purpose prescribed by the Plan Participant's Physician;
22. Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes or for Compound, Specialty, and Experimental drugs;
23. Medical treatment related to Infertility
24. Transcutaneous Electrical Nerve Stimulation (TENS) units;
25. Medical Treatment for obesity, including bariatric surgery and anorectics;
26. Medical Treatment related to sex transformation surgery or the reversal thereof;
27. Medical Treatment Acne;
28. Lab specimen handling and delivery fees or after hours and weekend facility fees, unless related to Emergency Services;
29. Genetic medicine, genetic testing, surveillance testing and/or screening procedures for genetically predisposed conditions indicated by genetic medicine or genetic testing, including but not limited to amniocentesis, genetic screening, risk assessment, preventive and prophylactic surgeries recommended by genetic testing, and/or any procedures used to determine genetic pre-disposition, provide genetic counseling, or administration of gene therapy;

30. Medical Treatment for the diagnosis and testing for or related to any learning disability or congenital condition, except this does not include congenital conditions for a child if the delivery is covered under this insurance;
31. Private-duty nursing services and Custodial Care;
32. Expenses incurred for an Injury or Sickness after the Policy Period shown in the Schedule of Benefits or incurred after the termination date of coverage;
33. Regular health checkups, routine physical or health examinations, sports physicals, gynecologic health screenings, routine baseline or screening mammograms, prostate and/or colorectal examinations and related laboratory tests, annual health checkups, immunizations indicated on the Recommended Immunization Schedule by the Centers for Disease Control and Prevention, and tuberculosis tests in excess of benefits provided elsewhere in this coverage, if any.
34. Ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste, from combustion of nuclear fuel, the radioactive, toxic, explosive or other hazardous properties of any nuclear assembly or nuclear component of such assembly;
35. Plan Participant being exposed to the Utilization of Nuclear, Chemical or Biological Weapons of Mass Destruction.

CLAIM PROVISIONS

NOTICE OF CLAIM:

Written notice of death, or Injury or Sickness must be given to Us within 60 days after a Covered Loss occurs or begins or as soon as reasonably possible. Notice can be given to Our authorized licensed agent. Notice should include the Policyholder's name and number and a Plan Participant's name and address.

If written notice is not received within 60 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

1. it can be shown that it was not possible within reason to submit notice within the 60 day period; and
2. it is further shown that notice was given as soon as possible.

CLAIM FORMS:

When We receive the notice of claim, We will send forms for filing proof of loss. If claim forms are not sent within 15 days after receipt of such notice, the Proof of Loss requirements stated below will be deemed to have been met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:

Written notice of Accidental Death, or Injury or Sickness must be given to Us within 60 days after a Covered Loss occurs or begins or as soon as a reasonably possible. Notice can be given to Our authorized licensed agent. Notice should be include the Policyholder’s name and number and a Plan Participant’s name and address.

In case of claim for any other loss, proof must be furnished within 60 after the date of such loss.

If the proof of loss is not submitted within 60 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

1. it can be shown that it was not possible within reason to submit notice within the 60 day period; and
2. it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIMELY FILING OF CLAIMS:
All claims for benefits under the Policy must be submitted to Us no more than 365 days from the date of service or date of death.

TIME OF PAYMENT OF CLAIMS:
Benefits due under the Policy for a loss, other than a loss for which the Policy provides installments, will be paid within 30 days after Our receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for loss for which the Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid within 30 days after Our receipt of a written proof of loss, unless otherwise stated in the Description of Benefits.

Failure to pay claims within 30 days shall entitle the claimant or assignee to interest at the rate set by the state's prompt payment requirements from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. A claimant or their assignee shall be notified by Us of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim. Any required interest payments shall be made within 30 days after the payment.

PAYMENT OF CLAIMS:
All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of the Policy.

All other benefits will be paid to the Plan Participant suffering the loss. If the Plan Participant dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of the Policy.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to the selected AD&D benefit to a relative by blood or marriage whom We believe is equitably entitled. This good faith payment satisfies Our legal duty to the extent of that payment.

Any other accrued benefits which are unpaid at a Plan Participant's death may, at Our option, be paid either to his beneficiary or to his estate. All other benefits, unless specifically stated otherwise, will be paid to a Plan Participant.

DESIGNATION OR CHANGE OF BENEFICIARY:
Each Plan Participant may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order:

1. Beneficiaries designated in writing by the Plan Participant for the Policy on file with the Policyholder, if any, otherwise;
2. Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise;
3. In equal shares to the members of the first surviving class of those that follow, if any:
    a. a Plan Participant's lawful spouse, if not legally separated or divorced, or domestic partner or Civil Union Partner;
    b. a Plan Participant's natural child, adopted child, foster child, stepchild, or other child for whom the Plan Participant has or had legal guardianship (proof will be required); or
    c. a Plan Participant's parents, whether natural, step or adoptive; or
    d. a Plan Participant's Sisters or Brothers, otherwise.

4. The estate of the Plan Participant.

A Plan Participant may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Plan Participant is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt.

A Dependent's beneficiary is the Plan Participant. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Plan Participant's estate.

PHYSICAL EXAMINATION AND AUTOPSY:
We have the right to have a Physician of Our choice examine the Plan Participant as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death. We will pay the cost of the examination or autopsy.

RECOVERY OF OVERPAYMENT:
If benefits are overpaid, or paid in error We have the right to recover the amount overpaid or paid in error by any of the following methods.

1. A request for lump sum payment of the amount overpaid or paid in error or
2. Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error.

RECOVERY OF BENEFITS:
We reserve the right to recover from a Plan Participant any benefits We have paid to him for injuries:

1. Received in a Covered Accident; and
2. Which are covered under:
    a. workers' compensation or similar statutory remedies available under law; or
    b. Any employer's liability Insurance.

It will be assumed that the Plan Participant is in receipt of such benefits unless he gives us proof such benefits have been denied to him.

"Recovery" means monies paid to the Plan Participant through judgment, settlement or otherwise to compensate for all losses caused by the Injury.

RIGHT OF REIMBURSEMENT / SUBROGATION:
If a Plan Participant recovers expenses for Sickness or Injury that occurred due to the negligence of a Third Party, where permitted by state law We have the right to first reimbursement for all benefits We paid from any and all damages collected from the negligent Third Party for those same expenses whether by action at law, settlement, or compromise, by the Plan Participant, the Plan Participant's parents if the Plan Participant is a minor, or the Plan Participant's legal representative as a result of that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the Third Party admits liability.

We are assigned the right to recover from the negligent Third Party, or his or her insurer, to the extent of the benefits We paid for that Sickness or Injury. You are required to furnish any information or assistance, or provide any

documents that We may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the Third Party admits liability.

LEGAL ACTIONS:
No legal action may be brought to recover on the Policy within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:
The Policy, the application of the Policyholder, a copy of which is attached, endorsements, riders, and attached papers constitute the entire contract between the parties. If an application of a Plan Participant is required, the application of any Plan Participant, at Our option, may also be made a part of this contract.

All statements made by the Policyholder, Participating Organization, or by a Plan Participant are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2-years from the Plan Participant's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

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

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

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

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

1. The two year period after the expiration of the Policyholder's coverage; or
2. The final adjustment and settlement of all claims under the Policyholder's coverage.

REPORTING REQUIREMENTS:
The Policyholder or its authorized agent must report to us, by the premium due date:

1. The names of all Plan Participants on the Effective Date of the Policy;
2. The names of all persons who are Plan Participant after the Effective Date of the Policy;
3. The names of those persons whose insurance has terminated; and
4. Additional information required as agreed to by Us and the Policyholder.

EVIDENCE OF COVERAGE:
An Evidence of Coverage of insurance will be delivered to the Participating Organization for delivery to each Plan Participant. Each Evidence of Coverage will list the benefits, conditions and limits of the Evidence of Coverage. It will state to whom the benefits will be paid.

POLICY TERMINATION:
We may terminate coverage on or after the anniversary of any premium due date. The Policyholder may terminate its coverage on any premium due date. Written notice must be given at least 31 days prior to such premium due date.

OTHER COVERAGE WITH US:
At any one time each Plan Participant may have only one Evidence of Coverage issued by Us having coverage similar to that described in the Policy. If we find the Plan Participant has more than one such Evidence of Coverage, coverage will be provided under the plan that has been in force for the longer period of time. We will refund premiums paid for all other Evidence of Coverages for concurrent periods of coverage.

CLERICAL ERROR:
Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

ASSIGNMENT:
No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

INSOLVENCY:
The insolvency, Bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in the Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Plan Participants under the Policy.

WAIVER:
Failure of the Company to strictly enforce its rights under the Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

LAW AND JURISDICTION
This Policy and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by, and construed in accordance with, the law of England and Wales.

The courts of England and Wales shall have exclusive jurisdiction over any dispute or claim arising out of or in connection with this Policy or its subject matter or formation (including non-contractual disputes or claims).

Insurance Act 2015 - Remedies for breach of the duty of fair presentation

1. If, prior to entering into this insurance contract, the Insured shall breach the duty of fair presentation, the remedies available to the Insurer are set out below.
    a. If the Insured's breach of the duty of fair presentation is deliberate or reckless:
        i. The Insurer may avoid the contract, and refuse to pay all claims; and,
        ii. The Insurer need not return any of the premiums paid.
    b. If the Insured's breach of the duty of fair presentation is not deliberate or reckless, the Insurer's remedy shall depend upon what the Insurer would have done if the Insured had complied with the duty of fair presentation:
        i. If the Insurer would not have entered into the contract at all, the Insurer may avoid the contract and refuse all claims, but must return the premiums paid.
        ii. If the Insurer would have entered into the contract, but on different terms (other than terms relating to the premium), the contract is to be treated as if it had been entered into on those different terms from the outset, if the Insurer so requires.
        iii. In addition, if the Insurer would have entered into the contract, but would have charged a higher premium, the Insurer may reduce proportionately the amount to be paid on a claim (and, if applicable, the amount already paid on prior claims). In those circumstances, the Insurer shall pay only X% of what it would otherwise have been required to pay, where X = (premium actually charged/higher premium) x 100.
2. If, prior to entering into a variation to this insurance contract, the Insured shall breach the duty of fair presentation, the remedies available to the Insurer are set out below.
    a. If the Insured's breach of the duty of fair presentation is deliberate or reckless:
        i. The Insurer may by notice to the Insured treat the contract as having been terminated from the time when the variation was concluded; and,
        ii. The Insurer need not return any of the premiums paid.
    b. If the Insured's breach of the duty of fair presentation is not deliberate or reckless, the Insurer's remedy shall depend upon what the Insurer would have done if the Insured had complied with the duty of fair presentation:
        i. If the Insurer would not have agreed to the variation at all, the Insurer may treat the contract as if the variation was never made, but must in that event return any extra premium paid.
        ii. If the Insurer would have agreed to the variation to the contract, but on different terms (other than terms relating to the premium), the variation is to be treated as if it had been entered into on those different terms, if the Insurer so requires.
        iii. If the Insurer would have increased the premium by more than it did or at all, then the Insurer may reduce proportionately the amount to be paid on a claim arising out of events after the variation. In those circumstances, the Insurer shall pay only X% of what it would otherwise have been required to pay, where X = (premium actually charged/higher premium) x 100.
        iv. If the Insurer would not have reduced the premium as much as it did or at all, then the Insurer may reduce proportionately the amount to be paid on a claim arising out of events after the variation. In those circumstances, the Insurer shall pay only X% of what it would otherwise have been required to pay, where X = (premium actually charged/reduced total premium) x 100.

Remedies for breach of the duty of fair presentation – group insurance

3. If this insurance contract provides cover for any person who is not a party to the contract ("a covered person"), and a fraudulent claim is made under the contract by or on behalf of a covered person, the Insurer may exercise the rights set out in clause (1) and (2) above as if there were an individual insurance contract between the Insurer and the covered person. However, the exercise of any of those rights shall not affect the cover provided under the contract for any other person.

Nothing in these clauses is intended to vary the position under the Insurance Act 2015.

LMA9121 (amended); 16 March 2016

Insurance Act 2015 - Fraudulent claims clause

1. If the Insured makes a fraudulent claim under this insurance contract, the Insurer:
    a. Is not liable to pay the claim; and
    b. May recover from the Insured any sums paid by the Insurer to the Insured in respect of the claim; and
    c. May by notice to the Insured treat the contract as having been terminated with effect from the time of the fraudulent act.
2. If the Insurer exercises its right under clause (1)(c) above:
    a. The Insurer shall not be liable to the Insured in respect of a relevant event occurring after the time of the fraudulent act. A relevant event is whatever gives rise to the Insurer's liability under the insurance contract (such as the occurrence of a loss, the making of a claim, or the notification of a potential claim); and,
    b. The Insurer need not return any of the premiums paid.

Fraudulent claims – group insurance

3. If this insurance contract provides cover for any person who is not a party to the contract ("a covered person"), and a fraudulent claim is made under the contract by or on behalf of a covered person, the Insurer may exercise the rights set out in clause (1) above as if there were an individual insurance contract between the Insurer and the covered person. However, the exercise of any of those rights shall not affect the cover provided under the contract for any other person.

Nothing in these clauses is intended to vary the position under the Insurance Act 2015.

LMA5256; 16 March 2016

Lloyd's Managing Agents are authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Their Firm Reference Number(s) and other details can be found on the Financial Services Register at www.fca.org.uk.

COMPLAINTS

Every effort is made to provide you with a high standard of service. However, occasionally disputes or misunderstandings can arise and you need to know what to do.

If you wish to make a complaint, your complaint should be made in writing to the Program Manager as defined in your Evidence of Coverage or Plan Document.

Program managed and administered by
The Lewer Agency, Inc.
Attn: Claims Department
4534 Wornall Road
Kansas City, MO 64111

Toll Free: 800.821.7710
Fax: 816-756-0531
Email: lewermarksupport@lewer.com

Further Steps
If you remain dissatisfied and are unable to resolve the situation you may ask the Complaints Department at Brit Syndicates Limited to review the case without prejudice to their rights in law.
The address is:
Brit Global Specialty Complaints Department
The Leadenhall Building
122 Leadenhall Street
London EC3V 4AB

Email: BGS.Complaints@britinsurance.com
You can also refer your complaint to the Complaints team at Lloyd's. Their contact details are:
Tel: +44 20 7327 5693
e-mail complaints@lloyds.com
Website: www.lloyds.com/complaints

Details of Lloyd's complaints procedures are set out in a leaflet "Your Complaint – How We Can Help" available at www.lloyds.com/complaints and also available from the above address. If you remain dissatisfied after Lloyd's has considered your complaint, you may be entitled to refer your complaint to the United Kingdom Financial Ombudsman Service; further details will be provided at the appropriate stage of the complaint process.

Data Protection
Please not that sensitive health and other information that you provide may be used by us, our representatives, the insurers and the industry governing bodies and regulators to process your insurance, handle claims and prevent fraud. This may involve transferring information to other countries (some of which may have limited or no data protection laws). We have taken steps to ensure your information is held securely.
Where sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use as set out above.

Information we hold will not be shared with third parties for marketing purposes. You have the right to access your personal records.