COMPASS Student Insurance

# J-Care Plan

## International Student Health Certificate
## Individual Coverage
## Policy ID: SEC-015

This policy is administered by:

GBG
Insurance Without Borders™

Compass is a SECUTIVE brand

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Welcome! This is a short-term medical Plan intended to provide Accident and Illness coverage while you are temporarily away from your Home Country and studying abroad.

While you are temporarily residing in the United States, there are requirements and instructions on how to maximize benefits and receive reimbursements for Prescription Medications, Medical claims, and other benefits covered under this Plan. There are also requirements for Pre-Authorization of specified medical care. Dedicated GBG Assist personnel are available to assist you.

- ***Using an In-Network medical Provider in the U.S. provides full reimbursement of eligible medical expenses after satisfying a Deductible and/or Copayment***. See the section titled "Preferred Provider Network". For assistance with locating a Provider, you may contact GBG Assist.
- ***Pre-Authorization is a process for obtaining approval for specified non-emergency, medical procedures or treatments***. Failure to Pre-Authorize when required will result in a reduction in payment by the Insurer. See the section titled, "Pre-Authorization Requirements and Procedures" for more complete details.
- ***Prescription Medication must be obtained from any CVS/Caremark pharmacy***. Present your Medical Identification card to the pharmacist and a discount will be applied. Payment is due at the time of purchase. Follow the claims filing procedures for reimbursement per the benefits shown under the Schedule of Benefits. See the section titled, "How to File a Claim" for instructions on reimbursement. A list of participating pharmacies can be viewed at www.gbg.com.
- ***Hospital Emergency Rooms*** should only be used in medical emergency situations. A medical emergency situation is where your life or health is in jeopardy. Using an emergency room is very expensive.

## How You Can Reach Us

**Customer Service, Pre-Authorization, and Help Locating a Provider (24/7)**

| | |
|---|---|
| ➢ Worldwide Collect | +1.905.669.4920 |
| ➢ Inside USA/Canada Toll Free | +1.866.914.5333 |
| ➢ Email: | GBGAssist@gbg.com |
| ➢ Website: | www.gbg.com |

We invite you to visit our Member Services Portal at www.gbg.com and register as a New Member. The Member Services Portal allows you to conveniently access our Provider directory, download forms, submit claims, and utilize other valuable tools and services.

We look forward to providing you with this valuable insurance protection and outstanding service during your period of study.

## SCHEDULE OF BENEFITS

| BENEFIT COVERAGE | BENEFIT | |
|---|---|---|
| **Benefit Maximum** | $100,000 per Injury or Sickness | |
| **Plan Deductible per Participant** | $250 per Period of Insurance | |
| **Student Health Center Copay** | $5 per visit (not subject to plan deductible) | |
| **Coinsurance**<br>**In-Network:** | 80% of Preferred Allowance | |
| **Out-of-Network:** | 80% of Usual, Customary, & Reasonable (UCR) Charges | |
| | **In-Network Provider Benefit** | **Out-of-Network Provider Benefit** |
| **Accident and Sickness Medical Benefit** | $100,000 per Injury or Sickness | |
| **Hospital Room & Board Benefit** | 80% of the Semi-Private Room Rate | 80% of UCR |
| **Intensive Care/Cardiac Care Unit Benefit** | 80% of Preferred Allowance | 80% of UCR |
| **Hospital Miscellaneous Expense Benefit** | 80% of Preferred Allowance | 80% of UCR |
| **Surgeon (In or Outpatient) Benefits** | 80% of Preferred Allowance | 80% of UCR |
| **Assistant Surgeon Benefit** | 80% of Preferred Allowance | 80% of UCR up to 25% of the Surgeon Allowance |
| **Pre-Admission Testing Benefit** | 80% of Preferred Allowance | 80% of UCR |
| **Anesthesia Benefit** | 80% of Preferred Allowance | 80% of UCR |
| **Day Surgery Miscellaneous Benefit** | 80% of Preferred Allowance | 80% of UCR |
| **Diagnostic X-Ray and Lab Benefit** | 80% of Preferred Allowance | 80% of UCR |
| **Ambulance Benefit** | 80% of Preferred Allowance | 80% of UCR |
| **Physician Visit Benefit (Inpatient)** | 80% of Preferred Allowance, limited to 1 visit per day | 80% of UCR, limited to 1 visit per day |
| **Physician Visit Benefit (Outpatient)** | 80% of Preferred Allowance, limited to 1 visit per day | 80% of UCR, limited to 1 visit per day |
| **Consultant Physician Benefit** | 80% of Preferred Allowance | 80% of UCR |
| **Radiation/Chemotherapy Benefit** | 80% of Preferred Allowance | 80% of UCR |
| **Emergency Room Benefit** | 80% of Preferred Allowance, subject to a $250 copay, waived if admitted | 80% of UCR, subject to a $250 deductible, waived if admitted |
| **Emergency Dental Expense Benefit** | 80% of Preferred Allowance, up to $500 maximum | 80% of UCR, up to $500 maximum |
| **Palliative Dental** (includes treatment for immediate relief of infected tooth or gum) | 80% of Preferred Allowance, up to $350 maximum | 80% of UCR, up to $350 maximum |
| **Physiotherapy Expense Benefit - Inpatient** | 80% of Preferred Allowance, limited to 1 visit per day | 80% of UCR, limited to 1 visit per day |
| **Physiotherapy Expense Benefit - Outpatient** | 80% of Preferred Allowance, limited to 1 visit per day | 80% of UCR, limited to 1 visit per day |

| BENEFIT COVERAGE | BENEFIT | |
|---|---|---|
| **Durable Medical Equipment Expense Benefit** | 80% of Preferred Allowance | 80% of UCR |
| **Emergency Medical Evacuation Expense Benefit** | 100% of actual expense, up to $50,000 | |
| **Return of Mortal Remains** | 100% of actual expense, up to $25,000 | |
| | **In-Network Provider Benefit** | **Out-of-Network Provider Benefit** |
| **Prescription Drug Expense Benefit** | | |
| **Dispensed by a Student Health Center** | 80% of each 30 days supply | |
| **Dispensed while Inpatient at a Hospital** | 80% of the Preferred Allowance | 80% of UCR |
| **Outpatient Prescription Drugs** | 80% of each 30-day supply | 80% of each 30-day supply |
| **Accidental Death & Dismemberment** | Up to $25,000 | |

## 1.0 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.

Non-United States Citizens 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, 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. J1 valid visa holder. (An F1 visa holder on OPT is not eligible); 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.

Spouses of the above eligible Class whose Application has been accepted by the Company.

Natural or legally adopted Dependent unmarried children of an above eligible Class from the moment of birth and under 26 years of age and whose Application has been accepted by the Company.

**WAITING PERIOD on Pre-existing condition:** 6 months

## 2.0 FULL EXCESS MEDICAL EXPENSE

If an Injury or Sickness to the Plan Participant results in his incurring Eligible Expenses for any of the services in the SCHEDULE OF BENEFITS, We will pay the Eligible Expenses incurred, subject to any applicable Deductible Amount, Benefit Period, and Coinsurance Percentage, that are in excess of Expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

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

1. While the person is a Plan Participant under the Policy; or
2. During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Expense must be incurred within the time frame shown 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.

## 3.0 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.

**AIDS** means Acquired Immune Deficiency Syndrome, as that term is defined by the United States Centers for Disease Control.

**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.

**Benefit Period** means the period of time from the date of the Accident causing the Injury [or Sickness] for which benefits are payable, as shown in the Schedule of Benefits, and the date after which no further benefits will be paid.

**Caregiver** means an individual employed for the purpose of providing assistance with activities of daily living to the Plan Participant or to the Plan Participant's Immediate Family Member who has a physical or mental impairment. The Caregiver must be employed by the Plan Participant or the Plan Participant's Immediate Family Member. A Caregiver is not a babysitter; childcare service, facility or provider; or persons employed by any service, provider or facility to supply assisted living or skilled nursing personnel.

**Child** means the Plan Participant's natural Child, adopted Child (or Child placed in the Plan Participant's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Plan Participant has legal guardianship (proof will be required). A Child must reside with the Plan Participant in a parent-Child relationship. NOTE: In the event the Plan Participant shares physical custody of the Child with another parent, the requirement that the Child reside with the Plan Participant will be waived.

**Child Caregiver** means an individual providing basic childcare service needs for the Plan Participant's minor children under the age of 18 while the Plan Participant is on the Trip without the minor children. The arrangement of being the Child Caregiver while the Plan Participant is on the Trip must be made 30 or more days prior to the Scheduled Departure Date.

**Civil Union Partner** means a party to a civil union who is entitled to the same legal obligations, responsibilities, protections and benefits that are afforded a spouse. Throughout the Policy, a party to a civil union shall be included in any definition or use of the terms such as spouse, Immediate Family, dependent, next of kin, and other terms descriptive of spousal relationships. This includes the terms 'marriage' or 'married' or variations thereon. The term spouse or dependent includes civil union couples whenever used.

**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 Deductible, if any, has been met.

**Company** means Brit Underwriting Limited on behalf of Syndicate 2987 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, Sickness 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.

**Deductible** means the dollar amount of Eligible Expenses which must be incurred and paid by the Plan Participant before benefits are payable under the Policy. It applies separately to each Plan Participant.

**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.

**Dependent** means a Plan Participant's:

1. lawful spouse, if not legally separated or divorced, or Domestic Partner, or Civil Union Partner.
2. unmarried Children under age 26.

The age limitations will not apply to a Plan Participant's unmarried Child who is dependent on the Plan Participant or other care providers for lifetime care and supervision, and incapable of self-sustaining employment by reason of mental or physical handicap that occurred before age 26. Proof of such dependence and incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.

**Dive/Diving** means recreational snorkeling or scuba diving, dive training or diving as a scuba instructor, dive master, underwater photographer or while performing research under the auspices and following the diving safety guidelines of the American Academy of Underwater Scientists. A Dive begins upon entry into the water and ends upon exit from the water. A Dive must occur in an area in which snorkeling and/or scuba diving is not prohibited. In the case of scuba Diving, the Plan Participant must be equipped with Personal Diving Equipment. Diving must be done by a person (a) At least 10 years of age and qualified as a diver; the holder of a valid diver's certificate (recognized by international diving organizations); and according to the generally accepted standards of the diving community or (b) who is in the process of obtaining his/her qualification as a diver and is under the supervision of and diving with a qualified diving instructor affiliated with a certifying organization or agency.

**Domestic Partner** means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Plan Participant and shared financial assets/obligations with the Plan Participant. Both the Plan Participant and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Plan Participant nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

**Economy Transportation** means the lowest published available transportation rate for a ticket on a Common Carrier matching the original class of transportation that the Plan Participant purchased for the Plan Participant's Trip.

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

**Emergency** means a Sickness or Injury 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 layperson 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 Payer 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."

**Health Care Plan** means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

1. Group or blanket insurance, whether on an insured or self-funded basis;
2. Hospital or medical service organizations on a group basis;
3. Health Maintenance Organizations on a group basis.
4. Group labor management plans;
5. Employee benefit organization plan;
6. Professional association plans on a group basis; or
7. Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended; or
8. Automobile no-fault coverage (unless prohibited by law).

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

**Home Health Care** means nursing care, treatment and Daily Living Services provided in the Plan Participant's home as part of an overall extended treatment plan. To qualify for Home Health Care Benefits:

1. the Home Health Care plan must be established and approved by the attending Physician, including certification that confinement in a Hospital or Extended Care Facility would be required if it were not for

Home Health Care; and Necessary care and treatment are not available from a Plan Participant's Immediate Family Member or other persons residing with the Plan Participant without causing undue hardship;

2. nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified Home Health Care agency and nursing service; and
3. Daily Living Services must be provided by the attending Physician or by the provider of the nursing care service.

"Daily Living Services" are cooking, feeding, bathing, dressing and personal hygiene services that are necessary to a person's care and health.

Home Health Care consists of, but shall not be limited to, the following:

- Part time and intermittent skilled nursing services: services given to the Plan Participant at least once every 60 days or as frequently as a few hours per day, several days per week.
- Therapeutic services: physical therapy occupational therapy; speech and hearing therapy; and
- Medical social services, medical supplies, drugs and medicines, related pharmaceutical services and laboratory services to the extent such charges or costs would have been covered under the Evidence of Coverage if the Plan Participant had remained in the Hospital.

**Host Country** means any country other than the country where a Plan Participant has his or her true, fixed and permanent home and principal establishment, 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
6. on its premises; or
7. in facilities available to it, on a pre-arranged basis;
8. 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
9. Is not a place for drug addicts, alcoholics or the aged.

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 an 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). A Member of the Immediate Family includes an individual who normally lives in the Plan Participant's household.

**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.

**Master Application** means the Application for the Master Policy.

**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.

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

1. Required, necessary and appropriate for the diagnosis or treatment of a Sickness or Injury;
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.

**Mountaineering** means the sport, hobby, or profession of walking, hiking, and climbing up mountains either: 1) utilizing harnesses, ropes, crampons, or ice axes; or 2) ascending 4,500 meters or above.

**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.

**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.

**Occurrence** means all losses or damages that are attributable directly or indirectly to one cause or one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one Occurrence without regard to the period of time or the area over which such losses occur.

**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 a Sickness or Injury, but who is not confined and is not charged for room and board.

**Outpatient Surgical Facility** means a surgical or medical center which has (1) permanent facilities for surgery; (2) organized medical staff of Physicians and registered graduate Registered Nurses; (3) is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under law.

**Out-of-Pocket Maximum** means the maximum dollar amount the Plan Participant is responsible to pay per Injury or Sickness. After the Plan Participant has reached the Out-of-Pocket Maximum, the Policy pays 100% of Eligible Expenses for the remainder of the Injury or Sickness. The Out-of-Pocket Maximum is met by accumulated Deductibles and Coinsurance. Penalties and amounts above the 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.

**Parachuting** means an activity involving the breaking of a free fall from an airplane using a parachute.

**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.

**Permanent Residence** means the country where a Plan Participant has his or her true, fixed and permanent home and principal establishment, and to which he or she has the intention of returning and holds a current and valid

passport.

**Physician** means a person who is a qualified practitioner of medicine. As such, he or she must be acting within the scope of his/her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Plan Participant, a Plan Participant's Spouse, son, daughter, father, mother, brother or sister or other relative.

**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 and Dependent eligible for coverage as identified in the Enrollment/Application who is 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.

**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 Face Page.

**Policyholde**r means the entity shown as the Policyholder in the Face Page.

**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 36-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; or 2) took or received a prescription for drugs or medicine.

**Pregnancy** means the physical condition of being pregnant, including Complication 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.).

**Rehabilitation Facility** means a non-residential facility that provides therapy and training rehabilitation services at a single location in a coordinated fashion, by or under the supervision of a physician pursuant to the law of the jurisdiction in which treatment is provided. The center may offer occupational therapy, physical therapy, vocational training, and special training such as speech therapy. The facility may be either of the following:

1. A Hospital or a special unit of a Hospital designated as a Rehabilitation Facility; or
2. A free standing facility.

**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 illness or disease which requires treatment by a Physician while covered by this Policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same 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 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, staff Nurses, and 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 Sickness or Injury 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.

**Transportation Expense** means the cost of Medically Necessary conveyance, personnel, and services or supplies.

**Usual, Customary and Reasonable** 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, Customary and Reasonable 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.

**We, Our, Us** means Brit Underwriting 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.

## 4.0 ELIGIBILITY FOR INSURANCE

Persons eligible to be a **Plan Participant** under the Policy are those persons described as an ELIGIBLE CLASS on the 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.

A Plan Participant Person's Dependent(s), as applicable, are eligible on the latest of the date:

1) the Plan Participant is eligible, if the Plan Participant has Dependents on that date; or
2) the date the person becomes a Dependent; or

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.

## 5.0 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 He becomes eligible, subject to any required waiting period, according to the referenced date requested and shown in the Application/Enrollment Form; or
4) The Date the Company approves the Application.

Newborn Children Coverage: Coverage for a newborn Child will begin from the moment of birth. You must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage for the newborn Child will terminate upon the expiration of the initial 31-day period.

Newborn Adopted Children Coverage: In the case of adoption of a newborn Child, coverage will be on the same

basis as a newborn Child if a written agreement to adopt such Child has been entered into by You prior to the birth of the Child, whether or not such agreement is enforceable.

Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of placement in Your home for the purpose of adoption or the date of an entry of an interim court order granting You temporary custody of the child, whichever comes first. A notice of placement for adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate upon the expiration of the initial 31-day period.

## 6.0 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 Plan Participant 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:

1) The date He is no longer in an Eligible Class; or
2) The date the Plan Participant returns to his or her Home Country; or;
3) The end of the period for which the last premium contribution is made; or
4) The date the Policy is terminated; or
5) The date the Plan Participant requests, in writing, that his/her coverage be terminated; or
6) The date the Plan Participant's participation in the Program terminates.

**Dependent's Termination Date**

A Dependent's coverage under the Policy ends on the earliest of:

1) The date the Policy terminates; or
2) The date the Plan Participant's coverage ends; or
3) The date the Dependent is no longer a Dependent; or
4) The last day of the period for which premiums have been paid.

## 7.0 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 an officer of the Policyholder or by any other person designated by the Policyholder 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 Plan Participant 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 advanced written or authorized electronic notice. Notice will be sent to the Plan Participant's most recent address in Our records.

However, the Company reserves the right to change rates 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 Plan Participant submits written Application to the Company, the Company accepts the Application and the Plan Participant makes payment of all overdue premiums.

# 8.0 DESCRIPTION OF BENEFITS

## 8.1 ACCIDENTAL DEATH AND DISMEMBERMENT

If, within one year from the date of an Accident or Injury covered by the Plan Document, the Plan Participant suffers from a Covered Loss listed below, 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:

1. Occurs during the course of time the Plan Participant is covered under the Plan Document; provided that this Insurance will not apply while such Plan Participant is riding in any civilian or military aircraft other than as expressly described above, unless previously consented to in writing by the Company.

Aggregate Limit $500,000

| Loss Description | Percentage of Principal Sum |
|---|---|
| Loss of Life | 100% |
| Loss of Speech and Loss of Hearing | 100% |
| Loss of Speech and one Loss of Hand, Loss of Foot or Loss of Sight of One Eye | 100% |
| Loss of Hearing and one Loss of Hand, Loss of Foot or Loss of Sight of One Eye | 100% |
| Loss of Hands (both), Loss of Feet (both), Loss of Sight or a combination of any two of Loss of Hand, Loss of Foot or Loss of Sight of One Eye | 100% |
| Quadriplegia | 100% |
| Paraplegia | 75% |
| Hemiplegia | 50% |
| Loss of Hand, Loss of Foot or Loss of Sight of One Eye (any one of each) | 50% |
| Uniplegia | 25% |
| Loss of Thumb and Index Finger of the same hand | 25% |

**Loss of a hand or foot** means complete Severance through or above the wrist or ankle joint.

**Loss of sight** means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

**Severance** means the complete separation and dismemberment of the part from the body.

## 8.2 AGGREGATE LIMIT - Accidental Death & Dismemberment Only

The Aggregate Limit of liability is shown in the Schedule of Benefits. We will NOT be liable for any amount over such limit for any one Accident.

If the total amount of benefits to be paid for Accidental Death & Dismemberment under this Plan Document is more than the Aggregate Limit shown in the Schedule of Benefits, the benefit amount payable for a Plan Participant's loss will be determined as a proportionate share of the Aggregate Limit for all Plan Participants.

## 8.3 ACCIDENT and SICKNESS MEDICAL EXPENSE BENEFITS

We will pay Accident and Sickness Medical Expense Benefits for Eligible Expenses. These benefits are subject to the Deductibles, Co-Payment, Coinsurance Factors, Benefit Periods, 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 Usual, Reasonable and Customary Charges incurred after the Deductible 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 30 days after the date of the Eligible Expense.

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

Eligible Medical Expenses include:

1. Hospital Admission Expenses: Charges for each hospital admission.
2. Outpatient Pre-Surgical Testing benefit – charges for Pre-surgical testing. A scheduled surgical procedure must occur within 3 days of the testing.
3. Nursing Services – Outpatient Charges for nursing services by a Registered Nurse or Licensed Professional.
4. Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.

## 8.4 HOSPITAL ROOM & BOARD BENEFIT

We will pay charges for the most common semi-private daily room rate 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, but not the date of discharge. 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.

## 8.5 INTENSIVE CARE / CARDIAC CARE UNIT BENEFIT

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

## 8.6 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.

## 8.7 SURGEON (IN OR OUTPATIENT) BENEFITS

We will pay 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. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Eligible Expenses for the additional surgeries.
2. A Physician, for assistant surgeon duties up to the Maximum Benefit shown in the Schedule of Benefits.

## 8.8 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.

## 8.9 PRE-ADMISSION TESTING BENEFIT

We will pay benefits for charges for Pre admission testing (inpatient confinement must occur within 3 days of the testing).

## 8.10 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.

## 8.11 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.

## 8.12 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 Accident 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.

## 8.13 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, 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.

## 8.14 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.

## 8.15 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.

Total visits per Injury will not exceed the combined Maximum shown in the Schedule of Benefits for All In-Hospital and Office Physician's Visits.

## 8.16 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.

## 8.17 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.

## 8.18 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 Accident 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.

## 8.19 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.

## 8.20 PALLIATIVE DENTAL

We will pay benefits as described in the Schedule of Benefits for eligible expenses for Palliative Dental. An eligible Palliative Dental condition will mean emergency pain relief treatment to natural teeth.

## 8.21 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 Usual, Reasonable and Customary expenses in excess of the Deductible 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 Disablement 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, adjustments, manipulation, acupuncture, massage or any form of physical therapy.

## 8.22 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. If Durable Medical Equipment is purchased, it is Our property and is to be returned to Us, at Our expense, upon completion of a Plan Participant's need, if so requested by Us.

We do not pay for the replacement of Durable Medical Equipment.

**Durable Medical Equipment which includes braces and appliances** 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.

## 8.23 EMERGENCY MEDICAL EVACUATION and RETURN of REMAINS

When You suffer loss of life for any reason or incur a Sickness or Injury during the course of Your Trip, the following benefits are payable, up to the Maximum Benefit Amount shown in the Schedule of Benefits.

1. Emergency Medical Evacuation: If the local attending Legally Qualified Physician and the authorized travel assistance company determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment.

   If You are traveling alone and will be hospitalized for more than 7 consecutive days and Emergency Evacuation is not imminent, benefits will be paid to transport one person, chosen by You, by Economy Transportation, for a single visit to and from Your bedside.
2. Return of Remains: In the event of Your death during a Trip, the expense incurred within 30 days from the date of the Covered Loss will be paid for minimally necessary casket or air tray, preparation and transportation of Your remains to Your primary place of residence in the United States of America or to the place of burial.

## 8.24 OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses, subject to the Deductible Amount, and 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.

Benefits are payable up to the Maximum Benefit Amount shown on the Schedule of Benefits.

## 9.0 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 Eligible 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 6 consecutive months;
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 Covered 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 Covered 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. Birth control devices and surgical procedures;
10. 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 covered under the Newborn Infants - Well Baby Care provision, if applicable), Immunizations (except as listed in Eligible expenses), immunization antibody testing, allergy tests, vitamins, and antitoxins; or the correction or treatment of a deviated septum;
11. Cosmetic, plastic, reconstructive, or restorative surgery unless such are Eligible expenses incurred for repair of a disfigurement caused from:
    a. A Covered Injury;
    b. a birth defect of an insured Eligible Dependent born while the mother was insured under this Policy.
12. 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;
13. 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;
14. 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;

15. 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;
16. 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;
17. 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;
18. Medical Treatment for Injuries sustained while taking part in: Mountaineering; hang gliding; Parachuting; bungee jumping; racing by horse, motor vehicle or motorcycle; snowmobiling; motorcycle/motor scooter riding; scuba diving, involving underwater breathing apparatus, unless PADI or NAUI certified; scuba diving, involving underwater breathing apparatus; snorkeling; water skiing; snow skiing; spelunking; parasailing; white water rafting; surfing, unless part of a school credit course; and snowboarding.
19. Medical Treatment for injury or sickness sustained by reason of a motor vehicle or motorcycle accident
    a. 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,

    b. if the Plan Participant was operating the motor vehicle or motorcycle while Intoxicated under the laws of the state in which the accident occurred,
    c. 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
    d. if the Plan Participant was not operating the motor vehicle or motorcycle in conformity with the restrictions of the driver's license or permit;
20. 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;
21. Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes or for Compound, Specialty, and Experimental drugs;
22. Treatment of Mental and Nervous Disorders;
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. Expenses incurred for an Accident or Sickness after the Policy Period shown in the Schedule of Benefits or incurred after the termination date of coverage;
32. 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.

33. 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;
34. Plan Participant being exposed to the Utilisation of Nuclear, Chemical or Biological Weapons of Mass Destruction.
35. Pregnancy or childbirth, miscarriage resulting from an accident, elective abortion; elective cesarean section; or any complications of any of these conditions; pregnancy or childbirth of a dependent when dependent child of an Plan Participant.

## 10.0 CLAIM PROVISIONS

**NOTICE OF CLAIM:**
Written notice of Accidental Death, or Injury or Sickness must be given to Us within 30 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 30 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 30 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 proof of loss must be furnished to Us in the case of a claim for loss for which the Policy provides periodic payment contingent upon continuing loss within 60 after the end of the period for which We are liable. Written proof that the loss continues must be furnished to Us at intervals required by us.

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 90 days from the date of service or date of Accidental 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 to interest at the rate of 9 per cent per annum 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. Accidental Death 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 $1,000 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 Accidental 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 Accidental Death 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, We have the right to 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.

## 11.0 GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:
The Policy, the Application of the Policyholder, a copy of which is attached, endorsements, riders, and the Application or participation agreement with the Participating Organization 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.

**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.

**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 Accidental Death 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 Plan Participant"), and a fraudulent claim is made under the contract by or on behalf of a Plan Participant, 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 Plan Participant. 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.

<u>Fraudulent claims – group insurance</u>

3) If this insurance contract provides cover for any person who is not a party to the contract ("a Plan Participant"), and a fraudulent claim is made under the contract by or on behalf of a Plan Participant, 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 Plan Participant. 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

## 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 Plan Administrator as defined in your Evidence of Coverage or Plan Document.

Plan Administrator
GBG Administrative Services
27422 Portola Parkway, Suite 110
Foothill Ranch, CA 92610 USA

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 73275693
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 note that sensitive health and other information that you provide may be used by us, our representatives, the insurers and 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.

## 11.1 SUBSCRIPTION AGREEMENT

I hereby apply to be a Plan Participant of the Fairmont Specialty Trust (the "Trust") and to participate in the insurance coverage extended by certain underwriters at Lloyd's (the "Insurers'") to Plan Participants under the Trust (the "Coverage"). I understand that the Coverage is not a general health insurance product, but is intended for use in the event of a sudden and unexpected event while traveling outside my Home Country. I understand that the Coverage extended to me will terminate upon my return to my Home Country unless I qualify for a Benefit Period or Home Country coverage. I understand that I may obtain full details of the Coverage by requesting a copy of the Master Policy from the Plan Administrator. I understand that the liability of the Insurer as underwriter of the Coverage is as provided in the Master Policy.

By acceptance of Coverage and/or submission of any claim for benefits, the Plan Participant ratifies the authority of the signer to so act and bind the Plan Participant.

The Plan Participant undertakes to make all premium payments as they fall due in respect of the Coverage extended. The Trustee shall not be responsible for the administration of such payments.

If the Plan Participant fails to make any premium payment due in respect of the Coverage extended, subject to the discretion of the Insurer, such Coverage will lapse.

The Plan Participant hereby confirms the accuracy of all information and validity of all representations and warranties provided to the Trustee in connection with its participation in the plan and/or the subscription for the insurance coverage, howsoever provided, including the terms of this Subscription Agreement, (together "Representations & Warranties"). The Plan Participant acknowledges that certain of such information will be relied upon by the Insurer as provider of the Coverage and that any inaccuracy therein may result in the invalidity of such Coverage as it relates to the Plan Participant, the loss of Coverage and all monies paid in relation thereto. The Plan Participant hereby undertakes to inform the Trustee of any change to any matter that forms the subject of any of the Representations & Warranties. The Plan Participant hereby undertakes to indemnify and hold harmless the Trustee against any loss or damage (including attorney's fees) occasioned by any inaccuracy in any Representations & Warranties or failure to advise the Trustee of any change in any matter that forms the subject of any of the Representations & Warranties. The Plan Participant agrees that the Trustee shall be entitled to rely on and to act in accordance with any written instruction purported to be provided by the Plan Participant and the Plan Participant hereby undertakes to indemnify and hold harmless the Trustee against any loss or damage (including attorney's fees) occasioned by the Trustee acting in accordance with any such instruction.

Payments under the terms of the Coverage shall be paid by the Insurers to the Plan Participant or directly to a provider if assignment of benefits has been authorized. The Trustee shall not be responsible for the administration of such payments.

**Underwritten by:**
The insuring company is Brit syndicate 2987 at Lloyd's,
which is rated "A" Excellent by A.M. Best

**Administered by:**
Global Benefits Group
27422 Portola Parkway, Suite 110
Foothill Ranch, CA 92610 USA