GROUP MEDICAL & TRAVEL ACCIDENT INSURANCE POLICY

This insurance contract (herein referenced as "the Policy") is concluded between the Policyholder and the Insurer and administered by the Coverholder on behalf of the Insurer. The Insurer agrees to provide insurance, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in the Policy. The Insurer and the Policyholder have agreed to all the terms and conditions of the Policy. 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 an Insured is required, the Application of any Insured, at Our option, may also be made a part of this contract.

INSURER	**KOOPERATIVA poisťovňa, a. s., Vienna Insurance Group** a company duly incorporated and existing under the laws of Slovakia, registered at Štefanovičova 4, 816 23 Bratislava, Slovakia, insurance reference number 00 585 441.
COVERHOLDER (authorized by the Insurer to underwrite and administer this Policy and manage claims for and on behalf of the Insurer):	**dhig GmbH,** registered and located at: Heumarkt 10/1, 1030, Vienna, Austria Registration number: FN 515759 w. The Assistance Service shall be arranged by the COVERHOLDER's subcontractors specified below.
ASSISTANCE SERVICE: (herein referenced as "the Assistance Service")	**In the United States & Canada and Mexico: One Team Health,** a wholly owned subsidiary of Argus Group Holdings Limited, a legal entity established under the legislation of Ontario, Canada with its headquarters registered at 140 Allstate Pkwy, Markham, ON L3R 5Y8. **In other countries: CORIS ASSISTANCE SRL**, a company incorporated under the laws of Romania, registered at at Union Building, 11 Ion Campineanu street, 010031 Bucharest, Romania, registration number: J40/927/2001, VAT number: RO13668533
POLICYHOLDER:	**Global Secutive GmbH**, registered at Stenzelbergstraße 10, 53340 Meckenheim, Germany Registration number: HRB 21329 by Handelregister Bonn/Rhein-Sieg Tax ID No.: 222/5723/1886
PARTICIPATING ORGANIZATION:	Council for Educational Travel USA (CETUSA)
POLICY NUMBER:	2024/171/1/43/0
EFFECTIVE DATE:	February 1, 2024. The Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Policyholder.
EXPIRATION DATE:	January 31, 2025
INSUREDS: (Eligibility Condition):	Participants of Cultural Exchange Program (herein referenced as "the Program") who are Non-United States Citizens traveling outside their Home Country, have their true, fixed and permanent addresses and principal establishments outside of the United States, and hold current and valid visas H2B, J, F, M, Q or a has a valid ESTA VWP when travelling to the United States, or United States Citizens traveling outside their Home Country, have their true, fixed and permanent addresses and principal establishments inside of the United States of America. Dependents of the Program participants are not eligible for coverage.
INSURANCE PREMIUM RATES:	Given in Appendix 1 attached hereto.

WELCOME

If you are temporarily residing in the United States, there are requirements and instructions on how to maximize benefits and receive reimbursements for Prescription Drugs, medical claims, and other benefits covered under this Policy. There are also requirements for Pre-Authorization of specified medical care. Dedicated Assistance Service personnel are available to assist you.

- **Using an In-Network medical provider in the U.S. provides full reimbursement of eligible medical expenses after a Deductible.** Utilizing providers that are Out-of-Network is a more expensive financial option. Refer to the Medical Identification card showing the Network provider.
- **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 Coverholder.
- **Hospital Emergency Rooms** should only be used in Medical Emergency situations. Triage is mandatory prior to seeking medical care. A Medical Emergency situation is where your life or health is in jeopardy. Using an emergency room is very expensive. If you use an emergency room for convenience or for any reason other than a serious medical emergency, you will be responsible for a large portion of the payment.
- **Assistance Service** is the dedicated 24 hours a day, 7 days a week customer service division, providing assistance on all medical services and emergency medical situations. In the event of a Medical Emergency, you can count on highly trained and experience case managers, trained nurses, and a medical director to work as a team to manage all aspects of your case, from the initial contact to the safe arrival back in your Home Country.

If you are studying in a country other than the United States, Assistance Service is available to guide you through the process of obtaining medical care in a foreign country.

How Assistance Service Can Be Reached

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

in the USA & Canada

U.S./Canada Toll-free:	+1 844 805 9444
Worldwide Collect:	+1 905 907 0074
Email:	oneteamhealth@dhig.net

in other countries

International Toll-free:	+1 833 982 1333
Email:	corisclaims@dhig.net

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

1. SCHEDULE OF BENEFITS

PART 1A: ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS

Benefits will be provided only for the coverages listed below and will be paid only up to the amounts shown. Benefits are not provided for coverages marked "NIL".

Sum Insured per insured person per Injury or Sickness:	$250,000
Deductible (Outpatient Services Only) Per Injury or Sickness:	$50
Coinsurance:	100% of Usual, Reasonable & Customary (URC) Charges or Preferred Allowance, if a contracted Provider is used
Terms of Payment:	Full Excess
Pre-Existing Conditions (subject to a Look back period):	Not Covered
Look back period for Pre-Existing Conditions:	6 months

BENEFIT COVERAGE	COVERED BENEFIT
Hospital Room & Board Benefit: Subject to Semi-private room rate	100% URC
Intensive Care/Cardiac Care Unit Benefit	100% URC
Hospital Miscellaneous Expense Benefit	100% URC
Surgeon & Assistant Surgeon (In or Outpatient) Benefits	100% URC
Pre-Admission Testing Benefit	100% URC
Anesthesia Benefit	100% URC
Day Surgery Miscellaneous Benefit	100% URC
Diagnostic X-Ray and Lab Benefit	100% URC
Ambulance Benefit (Ground or Air)	100% URC
Physician Visit Benefit (Inpatient or Outpatient)	100% URC
Consultant Physician Benefit	100% URC
Radiation/Chemotherapy Benefit	100% URC
Emergency Room Benefit in case of injury or illness • Triage is mandatory • Co-Payment only applies to services rendered in the USA	100% URC, subject to a $350 Co-Payment, waived if admitted
Emergency Dental Expense Benefit	100% URC
Palliative Dental	100% URC, up to $200 maximum benefit per tooth
Physiotherapy Expense Benefit - Inpatient	100% URC
Physiotherapy Expense Benefit - Outpatient	100% URC, up to $2,500 maximum
Durable Medical Equipment Expense Benefit	100% URC
Out-Patient Prescription Drug Benefit	100% URC
Mental & Nervous Conditions Expense Benefit	Outpatient: Payable at 80% URC, up to $5,000; Inpatient: Payable at 80% URC up to $25,000 lifetime maximum Three month waiting period for hospital expenses due to suicide, any attempt at suicide, or intentionally self-inflicted injury up to a lifetime maximum of $25,000
Emergency Treatment of a Pre-Existing Condition	100% URC, up to a maximum of $5,000 per Policy Period

With respect to outpatient prescriptions, the Policy will pay the stated percentage for each 30 day supply, until the stated Prescription Drug Benefit Maximum has been met.

NOTES:

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

COVID-19 Treatment Benefit

The following is paid at locally reasonable and customary costs within the relevant limits and subject to co-payments / deductibles established in other sections of Schedule of Benefits:

- PCR virus detecting test for COVID-19 if prescribed by the doctor in case of confirmed symptoms;
- treatment of COVID-19 infection, including hospitalization, medication and local transportation costs if allowed by the local authorities and if specialized transportation facilities available; and
- treatment of any complications resulting from COVID-19.

COVID-19 Treatment Benefit does not cover:

- evacuation to another country;
- rapid antibody testing (e.g. population screening tests for use by health authorities to monitor herd immunity);
- tests undergone by the insured person without doctor's prescription;
- tests required by the authorities, to be taken by persons crossing the country's borders;
- COVID-19 vaccination.

PART 1B: MEDICAL TRANSPORTATION BENEFITS

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

Pre-Existing Conditions (subject to a Look back period):	Same as those specified in section PART 1A: ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS
Look back period for Pre-Existing Conditions:	Same as those specified in section PART 1A: ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS

Sum Insured per insured person:	$250,000
Emergency Medical Evacuation, Medical Repatriation	100% of actual expense
Returns of Remains Benefit	100% of actual expense up to $25,000
Emergency Reunion	As further specified in this policy
Return Ticket Benefit	100% URC, up to $5,000 per Policy Period
Trip Interruption Benefit	As further specified in this policy

PART 1C: ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Sum Insured per insured person: $15,000

Personal accident/body injury leading to	Benefit In Percentage of Sum Insured
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%

Personal accident/body injury leading to	Benefit In Percentage of Sum Insured
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Thumb and Index Finger of the Same Hand	25%

Aggregate Limit per all persons insured under this Policy: $500,000

2. DEFINITIONS

The male pronoun includes the female whenever used.

Additional terms may be defined within the provision to which they apply.

Accident is an external, sudden, short-term, unintentional, not being a result of a disease or its Treatment, unforeseen concourse of circumstances, which occurred during the Policy Period, where against the will of an Insured Person his/her health is damaged or he/she dies. Accidents among other things include but are not limited to the following: illegal actions of third parties (including Terrorist Attacks), attempts of rescuing people or freight in peril; inhalation of gas or vapor, as well as absorption of poisonous or aggressive substances; muscle lacerations and injuries resulting from sharp movement; frostbite; drowning.:

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

Benefit Period means the period of time from the date of the Accident causing the Injury 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 Insured or to the Insured's Immediate Family Member who has a physical or mental impairment. The Caregiver must be employed by the Insured or the Insured'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 Insured's natural Child, adopted Child (or Child placed in the Insured's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Insured has legal guardianship (proof will be required). A Child must reside with the Insured in a parent-Child relationship. NOTE: In the event the Insured shares physical custody of the Child with another parent, the requirement that the Child reside with the Insured will be waived.

Child Caregiver means an individual providing basic childcare service needs for the Insured's minor children under the age of 18 while the Insured is on the Trip without the minor children. The arrangement of being the Child Caregiver while the Insured 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 Insurer is responsible for a specified covered service after the Deductible, if any, has been met.

Complications of Pregnancy means the following unforeseen complications of pregnancy as certified by a medical practitioner: toxaemia; gestational hypertension; pre-eclampsia; ectopic pregnancy; hydatidiform mole (molar pregnancy); hyperemesis gravidarum; ante partum haemorrhage; placental abruption; placenta praevia; post-partum haemorrhage; retained placenta membrane; miscarriage; stillbirths; medically necessary emergency Caesarean sections/ medically necessary termination; and any premature births or threatened early labour more than 8 weeks (or 16 weeks in the case of a multiple pregnancy) prior to the expected delivery date. Delivery by caesarean section is considered a complication of pregnancy if the caesarean section is *non*-elective. A caesarean section will be considered non-elective if the foetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if a caesarean section is not performed.

Co-Payment means a specified charge that the Insured 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 an Insured and results in a Covered Loss for which benefits are payable.

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

Coverholder (also hereinafter referred to as We, Us and Our) means the company dhig GmbH, which has been duly appointed by the Insurer to conclude and implement this insurance contract for and on behalf of the Insurer, including (but not limiting to) the following: collection of applications for insurance, underwriting (insurance risk assessment, customizing insurance benefits and conditions, and

pricing), issue of offers for insurance, issue and signing of additional agreements (addendums) to this insurance contract, Certificates and other documentation in relation to this insurance contract, subsequent Contract administration, insurance premium collection and refunds, and Claims handling, including appointment of the international assistance service providers.

Custodial Care means that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist an Insured, 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 Insured before benefits are payable under the Policy. It applies separately to each Insured.

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 an Insured'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 an Insured's unmarried Child who is dependent on the Insured 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 Coverholder 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.

Domestic Partner means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Insured and shared financial assets/obligations with the Insured. Both the Insured 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 Insured 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 Coverholder 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 Insured purchased for the Insured's Trip.

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

Emergency means a Sickness or Injury for which the Insured 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 as a result of complications of pregnancy;
- His bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

Emergency Treatment: Medical care for a Medical Emergency that is required for the immediate relief of an acute symptom or upon advice from a licensed physician cannot be delayed until your return to your Home Country.

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

- The drug or device cannot be lawfully marketed without approval of the Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;

- Reliable Evidence show that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or
- Reliable Evidence show that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

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

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

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

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

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 an Insured has his or her true, fixed and permanent home and principal establishment.

Home Health Care means nursing care, treatment and Daily Living Services provided in the Insured'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 Insured's Immediate Family Member or other persons residing with the Insured 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 Insured 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 Insured had remained in the Hospital.

Host Country means any country other than the country where an Insured 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
    a. on its premises; or
    b. in facilities available to it, on a pre-arranged basis;

6) Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and

7) Is not a place for 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 a Eligible Expense under the Policy.

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

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

Immediate Family means an Insured's spouse, domestic partner, civil union partner, parent (includes Step-parent), Child(ren) (includes legally adopted or step Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws).

Injury means bodily harm which results independently of disease or bodily infirmity, from an Accident after the effective date of an Insured'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 Insured sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Inpatient means an Insured who is confined in an institution and is charged for room and board.

Insurance means the coverage that is provided under the Policy.

Insurance Premium means a payment for insurance under this Policy due to be made by the Policyholder or by the Participating Organization, in the manner and within the time period as set in this Policy.

Insured means a Person and Dependent (if Dependent coverage is offered under this Policy) who meets the eligibility definition, holds a current and valid passport, for whom proper premium payment has been made when due, and who is therefore covered under the Policy.

Insurer means Insurer means duly licensed insurance organization indicated in the Policy, who ultimately carries the insurance risk under the Contract.

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 Insured is located at the time of an incident.

Maximum Benefit means the largest total amount of Eligible Expenses that the Coverholder will pay for the Insured as shown in the Insured's Schedule of Benefits as found on the ID card.

Medical Emergency: A sudden, unexpected, and unforeseen event caused by an Sickness or Injury that manifests itself by symptoms of sufficient severity that a prudent layperson would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

Medically Necessary means a treatment, drug, device, service, procedure or supply that is:
1) Required, necessary and appropriate for the diagnosis or treatment of an 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 Insured, the Insured'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.

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

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 an Insured.

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 Disaster means a flood, hurricane, tornado, earthquake, mudslide, tsunami, avalanche, landslide, volcanic eruption, fire, wildfire or blizzard that is due to natural causes.

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.

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 an Insured 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 Insured is responsible to pay during a Policy Term.

After the Insured has reached the Out-of-Pocket Maximum, the Policy pays 100% of Eligible Expenses for the remainder of the Policy Term.

The Out-of-Pocket Maximum is met by accumulated Deductible, Coinsurance and Co-payments. 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 directing/submitting its clients or members (natural persons) to the Policyholder for their subsequent enrollment into this Policy, subject to the approval by the Policyholder and underwriting by the Coverholder.

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 an Insured, an Insured'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.

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 between the Policy's Effective Date and Expiration Date, both dates inclusive, while the Insured meets Eligibility Conditions.

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

Pre-Existing Condition means an Injury, Sickness, disease, or other condition during the Look-back period (specified in the Schedule of Benefits), immediately prior to the date the Insured's coverage is effective for which the Insured 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.

Preferred Allowance refers to the amount an In-Network provider will accept as payment in full for covered medical expenses**.**

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 Coverholder approves.

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

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

Spouse means lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil 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 Insured, the Policyholder, the Participating Organization, the Coveholder or the Insurer.

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

Traveling Companion means a person or persons whose names appear with the Insured's on the same Travel Arrangements and who, during the Trip, will accompany the Insured.

Trip means a scheduled trip for which coverage for Travel Arrangements is requested and the premium is paid prior to the Insured's actual or Scheduled Departure Date of the Insured's Trip from the Insured's primary residence for which coverage is requested and the premium is paid.

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

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

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

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

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

You, Your, Yours, He or She means the Insured who meets the Eligibility Conditions of the Policy and whose insurance under the Policy is in force.

3. ELIGIBILITY CONDITION FOR INSURANCE

Conditions for a person to be eligible to be insured under this Policy are specified on its front page.

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 for the period when eligibility conditions were not met.

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.

4. EFFECTIVE DATES OF INSURANCE

Policy Effective Date:

The Policy begins on the Policy Effective Date shown on the Policy's Front Page 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.

Insured's Effective Date for Trip Interruption Coverage:

Coverage begins when the Insured departs on the first scheduled Travel Arrangement (or if they must use an alternate travel arrangement after the Scheduled Departure Date to reach the Trip destination, on the Scheduled Departure Date) for the Insured's Trip. This is the Insured's "Effective Date" and time for Trip Interruption.

Insured's Effective Date for all other Coverages:

A Person will become an Insured 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 Coverholder 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 Schedule of Benefits ; or
4) The moment He departs their Home Country airspace**;** or
5) The Date requested by the Participating Organization.

Addition of a Newborn Baby or Legally Adopted Child:

Newborn babies or a legally adopted child may be covered subject to the following:
1) The Insured must provide written notification to the Coverholder (Official Copy of Birth Certificate), and
2) A Health Statement must be submitted detailing the medical history of the child,
3) Coverage will become effective as of the date of notification, provided the Coverholder has approved the Health Statement. Coverage is not guaranteed and is based upon the health of the newborn baby/child, and
4) Any applicable Pre-existing condition limitation will apply.

5. 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 Coverholder 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 Policyholder to secure payment of all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Coverholder 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 Coverholder 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 Coverholder may terminate the Policy at any time by written mutual consent.

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

Termination Date of the Participating Organization. Coverage for a Participating Organization will terminate on the earliest of the following dates:

1) The date the Participating Organization no longer meets the definition of a Participating Organization;

2) The date ending the Coverage Month for which the last premium payment is made for the Participating Organization's insurance;

Termination of the Policy, or termination of coverage for a Participating Organization, under any conditions will be without prejudice to any claim incurred prior to termination.

Insured's Termination Date for all other Coverages:

Insurance for an Insured will end on the earliest of:
1) The date He is no longer meeting Eligibility Condition; or
2) The date the Insured returns to his or her Home Country or;
3) The date shown on the Evidence of Coverage issued by the Coverholder or
4) The date the Insured becomes a permanent resident of the United States or;
5) The date He reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
   a) The date the premium is fully earned; or
   b) The Expiration Date of the Policy.
   This does not include Reserve or National Guard duty for training;
6) The end of the period for which the last premium contribution is made; or
7) The date the Policy is terminated; or
8) The date the Insured requests, in writing, that his/her coverage be terminated; or
9) The date the Insured's participation in the Program terminates; or
10) The date the Insured's Trip is completed; or
11) The expiration date of the term of coverage, requested by the Participating Organization.

6. PREMIUM PROVISIONS

Premiums:

The Insurer provides insurance in return for payment of insurance premiums which it quotes for each Participating Organisation, Schedule of Benefits and individual period of insurance. 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.

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 Policyholder or the Participating Organization pays all the premiums due by the last day of the grace period, unless notice has been sent, in accordance with the TERMINATION provision, of the intent to terminate coverage under the Policy. Coverage will end if the premium is not paid by the end of the grace period.

Changes in Premium Rate:

The Insurer may change the premium rates from time to time with at least 60 days advanced written or authorized electronic notice. Notice will be sent to the Participating Organization's most recent address in Our records.

No change in rates will be made until 12 months after the Policy Effective Date.

However, the Insurer 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 (e.g. change of Eligibility Conditions).
2) A subsidiary, division, affiliated organization 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.
5) A change in the experience rating.

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.

Insurance Premium Refunds:

If the Participating Organization decides to cancel this Policy for an Insured, they can do so within 28 days of receipt of the Policy and will receive full credit for the Insurance Premium they paid, provided the Insured has not started his/her journey and no claim under this Policy has occurred. If the Participating Organization wants to cancel an Insured's Policy after this period or after the Insured has started his/her journey, they will receive a credit for the percentage of the Insurance Premium paid calculated on a pro-rata basis equivalent to the period of cover left unused provided that no claims have been made. If a claim has been made, or there has been an incident which may lead to a claim, the Insurer will not credit any Insurance Premium.

Reinstatement:

The Policy may be reinstated within 31 days of lapse if it is lapsed for nonpayment of premium, if all following conditions are met: the Participating Organization submits written Application to the Policyholder, both the Policyholder and the Coverholder accept the Application and the Policyholder or Participating Organization makes payment of all overdue premiums.

7. SCOPE OF COVERAGE

Benefits are payable under the Policy for Eligible Expenses incurred by an Insured for the items stated in the, Schedule of Benefits. Benefits will be payable to either the Insured or the Service Provider for Eligible Expenses incurred outside the Insured's Home Country. Coverage is available 24 hours per day while traveling to, from and while at the Insured's destination.

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

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

1) Is within the scope of the **DESCRIPTION OF BENEFITS PROVISIONS**; and

2) Occurs while the person is an Insured under the Policy.

8. FULL EXCESS MEDICAL EXPENSE

If an Injury or Sickness to the Insured results in his incurring Eligible Expenses for any of the services on the SCHEDULE OF BENEFITS, We will pay the applicable benefit, subject to any applicable Deductible Amount, Co-Payment and Coinsurance Percentage.

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

1) While the person is a Insured 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 stated on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under the Policy is shown on the SCHEDULE OF BENEFITS and is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

9. TRIAGE AND PRE-AUTHORIZATION GUIDELINES AND PROCEDURES

Triage is a required process by which an Insured contacts Assistance Service **prior** to obtaining medical care and is directed by Assistance Service where to go to receive the appropriate level of care by a network provider. TRIAGE IS MANDATORY prior to seeking medical care at an emergency room unless the Insured is having a life-threatening emergency such as difficulty breathing, excessive bleeding, traumatic injury. A $350 emergency room Co-Payment will be waived if the Insured is triaged and sent to the emergency room and is admitted to the hospital through the emergency room. The Assistance Service will make the final decision regarding Medical Necessity of the emergency room.

Pre-Authorization is a process by which an Insured Person or a medical person on behalf of the Insured obtains approval for certain non-emergency, medical procedures or treatments prior to the commencement of the proposed medical treatment.

This requires the Insured or a medical person on behalf of the Insured to submit a completed Pre-Authorization Request form to Assistance Service, a minimum of 5 business days prior to the scheduled procedure or treatment date.

Assistance Service will review the matter and respond to the Insured or the medical person. To assure reimbursement for covered services, written approval from Assistance Service must be received by the Insured prior to the commencement of the proposed medical treatment. It is the Insured Person's responsibility to make sure Pre-Authorization is obtained when necessary.

Pre-Authorization is required for the following services to maximize the benefits covered under the plan and to arrange for direct billing with the medical provider:

- Interfaculty Ambulance Transfer: No coverage if Pre-Authorization requirements are not met.
- Medical Evacuation: No coverage if not approved by the company.

Treatments and supplies listed below**:** Fifty percent (50%) reduction of eligible medical expenses if Pre-authorization requirements are not met. Maximum Penalty: $1,000**.** The penalty amount is not applied towards the deductible.

- In-Patient Hospitalization
- Outpatient Surgery
- All CAT scans, PET scans, and MRIs
- Air Ambulance (Air Ambulance service will be coordinated by the Assistance Service)
- Specialty Treatments and Highly Specialized Drugs
- Physical Therapy and Rehabilitation Services

The Insured will obtain a letter of authorization, prior to the performance of those services for both Pre-Authorization requests and Network information, Customer Service representatives are available 24 hours a day, every day.

Please note: Some treatment requests may require longer than 5 days for the review process to be completed.

Medical Emergency notifications must be received within 48 hours of the Admission or procedure. In instances of Medical Emergency, the Insured should go to the nearest Hospital or Provider for assistance even if that Hospital or Provider is not part of the Network and, the Coverholder will waive the 50% reduction of eligible medical expenses for failure to pre-authorize.

Notwithstanding the requirement to Pre-Authorize:

- Pre-Authorization approval does not guarantee payment of a claim in full, as Deductibles, charges in excess of Usual, Customary and Reasonable and out of pocket charges may apply.
- Benefits payable under the Policy are still subject to Eligibility at the time charges are actually incurred, and to all other terms, limitations, and exclusions of the Policy.

10. DESCRIPTION OF BENEFITS

10.1. 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 Insured;

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) **Skilled Nursing Facility** - charges for services as described in the schedule of benefits. The benefit provides skilled nursing 24 hours a day, seven days a week, under the supervision of a registered nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A SNF provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence.

   A SNF confinement must take place within 14 days from a hospital discharge and must represent care for the same condition which required hospitalization that lasted a minimum of three days. Care may not be custodial in nature (e.g., care which could be performed at home). The facility may not be primarily a place which provides general care for the aged.
6) Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.
7) Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items.

10.1.1. HOSPITAL ROOM & BOARD BENEFIT

We will pay charges for the **Average Semiprivate Charge** for each day of the Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule.

In computing the number of day's 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.

10.1.2. 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.

10.1.3. 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.

10.1.4. SURGEON (IN OR OUTPATIENT) BENEFITS

We will pa**y** charges for 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.

10.1.5. ASSISTANT SURGEON BENEFIT

If, in connection with such operation, an Insured requires the services of an Assistant Surgeon, We will pay the Covered Percentage of the Eligible expense incurred.

10.1.6. PRE-ADMISSION TESTING BENEFIT

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

10.1.7. 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.

10.1.8. 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.

10.1.9. DIAGNOSTIC X-RAY AND LABORATORY BENEFIT

We will pay the benefit if the Insured 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.

10.1.10. AMBULANCE BENEFIT

When, by reason of Injury or Sickness, an Insured 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 Insured 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 Insured is in a rural area, then air ambulance transportation to the nearest metropolitan area will be considered an 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.

10.1.11. 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.

10.1.12. 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.

10.1.13. CONSULTANT PHYSICIAN BENEFIT

If, by reason of Injury or Sickness, an Insured 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.

10.1.14. RADIATION/CHEMOTHERAPY THERAPY EXPENSE BENEFIT

We will pay the Covered Percentage for the Eligible expenses incurred by a Insured 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.

10.1.15. EMERGENCY ROOM BENEFIT

We will pay this benefit if the Insured 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.

10.1.16. 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 Insured's Trip for emergency dental treatment. Only expenses for emergency dental treatment required to restore or replace the Insured Person's sound natural teeth lost or damaged in an Accident incurred during the Trip will be reimbursed. Expenses incurred after the Trip are not covered. Damage to the teeth caused by biting or chewing is excluded from the insurance coverage.

10.1.17. 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.
Any other dental treatments and manipulations (oral exams, routine cleanings, X-Rays, fluoride application, sealants, space maintainers; X-Rays, filling/tooth decay treatment, including tooth decay implications (pulpitis, periodontitis), extraction and root canal therapy, surgery to remove a complicated, buried or impacted tooth, for example in the case of an impacted wisdom tooth, or to treat irreversible bone disease involving the jaw(s); gum treatments, restoration of the function of dental prostheses and the installation of new prostheses, crowns, bridges, and pivot teeth as well as related surgeries and treatments; orthodontic treatment) are excluded from the insurance coverage.

10.1.18. PHYSIOTHERAPY EXPENSE BENEFIT

We will pay benefits as described in the Schedule of Benefits for eligible Physiotherapy expenses incurred by the Insured. 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 Insurer'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 c**harges 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.

10.1.19. DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, an Insured requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Eligible Expenses incurred by an Insured for such Durable Medical Equipment. We pay the Covered Percentage of the Eligible Expenses incurred by an Insured 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 Insured's need, if so requested by Us.

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

Durable Medical Equipment includes all expenses related to prosthetics limbs and devices intended to replace the functionality of a body part. This includes but not limited to arms, hands, legs, and feet. This includes any therapy related to the usage of the new limb.

10.1.20. 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 Insured:
1) On or after the Insured'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. This benefit includes injectable drugs and other drugs administered in a Physician's office or other outpatient setting.

10.1.21. MENTAL AND NERVOUS CONDITIONS EXPENSE BENEFIT

If an Insured requires treatment for a Mental or Nervous Condition, We will pay for such treatment as follows:

a) BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT
When an Insured requires Hospital Confinement for treatment of a Mental or Nervous Condition, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement. Such confinement must be in a licensed or certified facility, including Hospitals.

b) BENEFITS FOR OUTPATIENT MENTAL AND NERVOUS SERVICES
We will pay the Covered Percentage of the Eligible Expenses incurred for the outpatient treatment of Mental and Nervous Conditions as defined up to one visit per day.
The Mental and Nervous Condition must, in the professional judgment of healthcare providers, be treatable, and the treatment must be Medically Necessary.
Outpatient treatment and Physician services include charges made by an outpatient treatment department of a Hospital, or community mental health facility, or charges for services rendered in a Physician's office. Treatment may be provided by any properly licensed Physician, psychologist or other provider as required by law.

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

We will pay the Covered Percentage of the Eligible Expenses incurred for treatment of biologically based mental Sickness, including:

a) Schizophrenia;
b) Schizoaffective disorder;
c) bipolar affective disorder;
d) major depressive disorder;
e) specific obsessive-compulsive disorder;
f) delusional disorders;
g) obsessive compulsive disorders;
h) anorexia and bulimia; and
i) panic disorder.

10.1.22. EMERGENCY TREATMENT OF A PRE-EXISTING CONDITION BENEFIT

In the event of a Medical Emergency resulting from a Pre-Existing Condition the Coverholder considers stable, this Policy will cover costs for the immediate relief of an acute symptom of a stable Pre-Existing Condition only, to the limit shown on the Schedule of Benefits, provided such Pre-Existing condition meets the following criteria. There are no benefits for continued care or Hospitalization beyond the treatment of the acute symptom.

1. The Insured must not be traveling against or in disregard of the recommendations, established Treatment programs, or medical advice of a Physician or other healthcare provider; and
2. The Insured must not be traveling with the intent or purpose to seek or obtain Treatment for the Pre-existing Condition; and
3. The Insured must not be traveling during a period of time when the Insured is preparing or waiting for, involved in, or undertaking a new, changed or modified Treatment program with respect to the Pre-existing Condition, and is not traveling subsequent to any such new, changed or modified Treatment program having been advised or recommended; and
4. The Pre-existing Condition must have been stabilized for at least thirty (30) days prior to the Effective Date without change in Treatment; and
5. A Pre-existing Condition that is a chronic or congenital condition, or that gradually becomes worse over time will not be considered as Emergency Treatment.

Unexpected Recurrence Benefit Period: Covered Expenses incurred for an unexpected Recurrence must be incurred during the Benefit Period stated in the Schedule of Benefits. Initial treatment of an injury or Sickness must occur within 30 days of the Injury or Sickness.

10.2. MEDICAL TRANSPORTATION BENEFITS

10.2.1. EMERGENCY MEDICAL EVACUATION, MEDICAL REPATRIATION 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 Program Medical Advisor 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.
2) Medical Repatriation: After initial treatment or diagnosis of a covered injury or sickness Our designated assistance provider will determine if the Insured can be repatriated when the medical condition prohibits continued participation in the sponsored program and it is determined that the Medically Necessary treatment can be performed in the Home Country. In this instance, if the assistance provider and the attending Physician determine the Insured may be medically repatriated and You choose not to travel back to Your Home Country for treatment, any further costs beyond that point cannot be claimed under this Policy for the same injury or sickness. The assistance provider will make the needed arrangements to ensure the appropriate level of medical care and mode of transportation is provided during the return Trip home.

   After the Insured is medically repatriated to his or her Home Country and has been medically released from treatment, We will cover the patient's one-way Economy Transportation return to resume their covered participation in the program if accepted by the sponsor program. The Insured must pay for the return Economy Transportation and submit a claim expense for reimbursement. Return Economy transportation to re-join their program must occur within 30 days of the medical release and coverage must still be in force.
3) 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 or to the place of burial**.**

10.2.2. EMERGENCY MEDICAL REUNION BENEFIT

When an Insured is traveling alone and is hospitalized for more than 5 days, the Coverholder will arrange and pay for round-trip economy-class transportation for one individual selected by the Insured from the Insured's Home Country to the location where the Insured is hospitalized and return to the current Home Country. The benefits payable will include:

1. The cost of a round trip economy air fare up to the maximum stated in the Schedule of Benefits;
2. Reasonable travel and accommodation expenses incurred in relation to the Emergency Medical Reunion up to the maximum stated in the Schedule of Benefits;
3. Hotel and meals to a maximum of $100 per day up to the maximum stated in the Schedule of Benefits.

The period of Emergency Medical Reunion is not to exceed 10 days, including travel.

All transportation in connection with an Emergency Medical Reunion must be pre-approved and arranged by an assistance company representative appointed by the Coverholder.

10.2.3. TRIP INTERRUPTION BENEFIT

This Policy reimburses cost of the most direct one-way air flight ticket by the economy class of a regular airline, if due to death of the Insured' Immediate Family Member, the Insured had to:

a) postpone his departure and join the Insured's Trip after the original Scheduled Departure Date or travel via alternate travel arrangements; or

b) interrupt his Trip after the Insured's Scheduled Departure Date. In this case, the cost of either the flight to the Insured's originally scheduled return destination is covered, or that to re-join the Trip.

10.2.4. RETURN TICKET BENEFIT

The Coverholder will pay for the cost of a Return Ticket to the maximum benefit stated in the, Schedule of Benefits for the Insured if the Insured's Immediate Family Member incurs death or serious Sickness in the Insured's Home Country, the Coverholder or authorized travel assistance company will organize and pay for expenses related to the return travel for the Insured from the Host Country to their Home Country. This benefit applies only when the Insured is unable to utilize his original return trip ticket.
With regards to serious Sickness or Sickness causing death of an Immediate Family Member, the following conditions apply:

1) The Sickness or Sickness causing death must manifest itself during the time the Insured is traveling outside their Home Country;
2) The Immediate Family Member has been hospitalized for more than 5 days;
3) The Sickness is deemed to be life threatening by the Immediate family member's Physician and the assistance company representative, appointed by the Coverholder;
4) Prior notification must be provided to the program and flight arrangements made through the Administrator.

10.3. ACCIDENTAL DEATH AND DISMEMBERMENT

If, within one year from the date of an Accident or Injury covered by the Policy that occurs during the Insured's Trip, the Insured suffers from an event specified in PART B of the Schedule of Benefits, We will pay the relevant percentage of the Sum Insured.

Benefits are payable if such Injury:

1) Occurs during the course of time the Insured is covered under the Policy;
2) Is sustained during such Trip while the Insured is riding as a passenger (but not as a pilot, operator or member of the crew) in or on, boarding or alighting from:
   a. any civilian aircraft having a current and valid Airworthiness Certificate, and piloted by a person who then holds a valid and current certificate of competency of a rating authorizing him to pilot such aircraft or
   b. any transport type aircraft operated by the Military Airlift Command (MAC) of the United States, or by the similar air transport service of any duly constituted governmental authority of any other recognized country or
   c. a Common Carrier provided that this Insurance will not apply while such an Insured is riding in any civilian or military aircraft other than as expressly described above, unless previously consented to in writing by the Coverholder.

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.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

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

10.3.1. EXPOSURE TO THE ELEMENTS OR DISAPPEARANCE

Subject to all other terms and conditions of the Policy, We will:

1) Pay the applicable benefit under **BENEFITS FOR ACCIDENTAL DEATH AND DISMEMBERMENT** for a Insured's loss specified therein, which results from unavoidable exposure to the elements or disappearance due to:
   a) The forced landing; stranding; sinking; or wrecking of a vehicle in which an Insured was traveling; and

b) Such Occurrence occurs from an Accident for which the Policy provides coverage; or

2) Presume that an Insured has died if:
   a) A vehicle in which he is traveling disappears; sinks; is stranded; or is wrecked; as a result of an Accident for which the Policy provides coverage; and
   b) His body is not found within one year of the Occurrence of (2) (a) above.

Payment of 100% of the AD&D benefit shall exhaust the AD&D benefits.

11. EXCLUSIONS

Unless stated otherwise on the Schedule of Benefits, the following services and benefits are excluded from coverage under this Policy:

1) Medical Treatment received by the Insured in his or her Home Country or country of regular domicile;

2) Medical Treatment received due to a Pre-Existing Condition or complication thereof;

3) Medical Treatment which is not Medically Necessary, as defined in the Policy;

4) Charges which are in excess of Usual, Reasonable and Customary;

5) Charges Reimbursable by Another Entity: Services, supplies, or treatment that are provided by or payment is available from:
   a. Workers' Compensation law, Occupational Disease law or similar law concerning job related conditions of any country;
   b. Another insurance company or government;
   c. A government entity due to an epidemic or public emergency;

6) Hearing aids, eye glasses, or contact lenses and the fitting or servicing thereof, examinations, or prescriptions except that the Policy will cover these expenses if the need for such results directly from a Covered Injury or covered eye surgery;

7) Birth control devices and surgical procedures, or any drug or treatment that promotes or prevents conception, or prevents childbirth, including but not limited to artificial insemination, treatment for infertility or impotency, tubal ligation, vasectomy, sterilization or reversal thereof;

8) Elective or preventive surgery or any Medical Treatment related to an elective or preventive surgery including, but in no way limited to breast reduction or enlargement, circumcision, immunization antibody testing, allergy tests, antitoxins; or the correction or treatment of a deviated septum;

9) 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; or
   c) a mastectomy (refer to the Post-Mastectomy Coverage provision);

10) 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;

11) Medical Treatment for injuries sustained in practice for or participation in professional or semi-professional sports; or in practice for or participation in intercollegiate sports in excess of benefits provided elsewhere in this coverage, if any;

12) 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; or participation in the armed forces, national guard, military, naval, or air services.

13) Medical treatment arising out of aeronautics or air travel, except while riding as a passenger on a regularly scheduled commercial airline,

14) Suicide, attempted suicide (including drug overdose) self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane

15) Medical Treatment for Injuries sustained while taking part in: Mountaineering; hang gliding; Parachuting; bungee jumping; racing by horse, motor vehicle or motorcycle; motorcycle/motor scooter riding or any other two or three wheeled motorized vehicle; scuba diving, involving underwater breathing apparatus, unless PADI or NAUI certified; water skiing; spelunking; parasailing;.

16) 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 Insured was operating the motor vehicle or motorcycle while Intoxicated under the laws of the state in which the accident occurred,

   c) if the Insured 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 Insured was not operating the motor vehicle or motorcycle in conformity with the restrictions of the driver's license or permit;

17) Medical Treatment for an Injury or Sickness resulting from the Insured'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 Insured's Physician;

18) Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes or for Compound, Specialty, and Experimental drugs;

19) Medical Treatment for obesity, including bariatric surgery and anorectics;

20) Medical Treatment related to sex transformation surgery or the reversal thereof;

21) 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;

22) 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;

23) 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;

24) 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.

25) Insured being exposed to the Utilization of Nuclear, Chemical or Biological Weapons of Mass Destruction.

26) Benefits for enrolling solely for the purpose of obtaining medical treatment, while on a waiting list for a specific treatment, or while traveling against the advice of a Physician;

27) Pregnancy & maternity:
   a. all expenses related to Pregnancy including but not limited to prenatal care, childbirth, miscarriage, abortion, premature birth, and all complications related to the mother or child,
   b. maternity or delivery preparation classes,
   c. elective Caesarean section,
   d. care or treatment for an individual acting as a surrogate;

28) AIDS/HIV, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARC), HIV infection, and all secondary diseases;

29) Alcohol and Drug Abuse:
   a. Treatment related to the detoxification, rehabilitation, and all support service;

b. Treatment of any Sickness or Injury arising directly or indirectly from alcohol or illegal drug abuse or other addiction, or any drugs or medicines that are not taken in the dosage or for the purposed prescribed;

30) Extended Care: All expenses related to Extended Care from an Extended Care Facility;

31) Hospice Care: Palliative and supportive services to terminally ill Insured's and their families;

32) Over-the-Counter and Non-Prescription Drugs: Over the counter drugs or non-prescribed drugs or medical devices, even if recommended by a Physician, including but not limited to the following:
   a. Tobacco dependency
   b. Weight reduction or appetite suppressant,
   c. Cosmetic drugs, even if ordered for non-cosmetic purposes
   d. Acne and rosacea drugs (including hormones and Retin-A), except for cystic and pustular acne, Vitamins, supplements, or herbs.

33) Personal Comfort and Convenience Items: Expense for items that are provided solely for personal comfort or convenience such as television, private rooms, housekeeping services, guest meals and accommodations, special diets, telephone charges, and take home supplies.

34) Podiatric Care: Routine foot care, orthopedic shoes or other supportive devices such as; arch supports, orthotic devices, or any other preventative services or supplies to treat the diagnosis of weak, strained, or flat feet or fallen arches.

35) Search and Rescue: Any expenses relating to search and rescue operations to find a Plan Participant in mountains, at sea, in the desert, in the jungle and similar remote locations including air/sea rescue charges for evacuation to shore from a vessel or from the sea;

36) Sexual Dysfunction: Any procedures, supplies, or drugs used to treat male or female sexual enhancement or sexual dysfunction such as erectile dysfunction, premature ejaculation, and other similar conditions;

37) Sleep Studies: Sleep studies and other treatments relating to sleep apnea;

38) Smoking Cessation: Treatments whether or not recommended by a Physician;

The Insurer shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit under this policy to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose the Insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, Bulgaria, Germany, the United Kingdom or the United States of America (provided this does not violate any regulation or specific national law applicable to the undersigned insurer).

12. CLAIM PROVISIONS

12.1. NOTICE OF CLAIM

Written notice of Accidental Death, or Injury or Sickness must be given to Us within 60 days after a Covered Loss occurs or begins or as soon as reasonably possible. Notice should include the Policyholder's name and number and an Insured's name and address.

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

1) it can be shown that it was not possible within reason to submit notice within the 60 day period; and

2) it is further shown that notice was given as soon as possible.

12.2. 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.

12.3. 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 90 days 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 90 days after the date of such loss.

If the proof of loss is not submitted within 90 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 90 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.

12.4. 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 percent 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.

12.5. 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 Insured suffering the loss. If the Insured 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 an Insured'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 an Insured.

12.6. DESIGNATION OR CHANGE OF BENEFICIARY

Each Insured 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 Insured 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) An Insured's lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner;
    b) An Insured's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Insured has or had legal guardianship (proof will be required); or
    c) An Insured's parents, whether natural, step or adoptive; or
    d) An Insured's Sisters or Brothers, otherwise.
4) The estate of the Insured.

An Insured 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 Insured 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 Insured. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Insured's estate.

12.7. PHYSICAL EXAMINATION AND AUTOPSY

We have the right to have a Physician of Our choice examine the Insured 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.

12.8. 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.

12.9. RECOVERY OF BENEFITS

We reserve the right to recover from an Insured 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 Insured is in receipt of such benefits unless he gives us proof such benefits have been denied to him.

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

12.10. RIGHT OF REIMBURSEMENT/SUBROGATION

If an Insured recovers expenses for Sickness or Injury that occurred due to the negligence of a third party, We have the right to first reimbursement for all benefits We paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the Insured, the Insured's parents if the Insured is a minor, or the Insured'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.

12.11. 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.

13. COMPLAINTS PROCESS

We make every effort to provide you with the highest standards of service. If on any occasion our service falls below the standard you would expect us to meet, the procedure below explains what you should do. You can write to the Coverholder's Complaints Team, who will arrange an investigation on your behalf, at: complaints@dhig.net or https://dhig.net/contact/

We will acknowledge your complaint within 5 working days, investigate your complaint and endeavour to send a final response to you as soon as practical.

If we are unable to provide you with a final response within 4 weeks (20 working days) of receipt of your complaint we will send you an update. If we are unable to provide you with a final response within 8 weeks (40 working days), we will write to you explaining why and advise you when you can expect a final response.

If, after our investigation is complete, it is impossible to reach an agreement, you may have the right to make an appeal directly to the Insurer at https://www.kooperativa.sk/.

These procedures do not affect your right to take legal action.

14. GENERAL PROVISIONS

14.1. All statements made by the Policyholder, Participating Organization, or by an Insured 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 Insured'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.

14.2. 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.

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

14.4. The Policyholder or its authorized agent must report to us, by the premium due date:
1) The names of all Insureds on the Effective Date of the Policy;
2) The names of all persons who are insured 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.

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

14.6. This insurance shall be governed by the laws of and subject to the exclusive jurisdiction of the courts of the Policyholder's country of registration.

15. NOTICE OF PRIVACY PRACTICES

15.1. For the purpose of entering into, implementing, and renewing the Policy, the Insurer and the Coverholder will need the Personal data of persons to be insured, Insured Persons, and Dependents. Any Personal data requested will be adequate, relevant and limited to what is necessary. If the person to be insured/Insured Person/Dependent does not wish to provide this to the Coverholder, the Coverholder will not be able to arrange entering into and implementation of the Policy request (e.g. tailoring offerings, preparing the Policy wording, handling Claims, etc.).

Processing of Personal data under the Policy shall be subject to the Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the Processing of Personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation). Therefore, all the definitions and terms as used in this Policy in respect of Processing of Personal data shall be interpreted with regards to this General Data Protection Regulation.

15.2. The following Personal data of data subjects will be processed based on the Policy:
- a. full name;
- b. age/date/place of birth;
- c. gender;
- d. address and other contact details (Country of residence, data related to planning on moving out of the Country of residence, Home County, e-mail address, telephone numbers);
- e. identification data — identification document number (i.e. passport number), identification document;
- f. social security-related data (including social security card number and other related data);
- g. membership in an organization (for instance, when the Policyholder arranges insuring its members under the Policy);
- h. travel-related data;
- i. IP addresses when visiting the Insurer's/Coverholder's webpage without disabling cookies;
- j. nationality, citizenship;
- k. marital status;
- l. employment-related data — data pertaining to occupation/profession (current and previous), employment start and termination date, vacation, pregnancy, as well as other working time and absence from work;

m. signature, photo;
n. results of Criminal Checks relating to prevention of Fraud and/or Terrorist Activities — if mandatory and requested by applicable laws;
o. Dependents/Spouse/Partner/Family Details;
p. bank and related financial/taxation data (including copies of bank cards, credit/debit card, and bank account details);
q. health and medical history, medical condition related Personal data, such as data on Medical Treatment, goods, and services as provided to data subjects; data resulting from medical reports or from death certificates; medical and medical Claims history; details of physical and psychological health or medical conditions; etc.;
r. other Personal data that may be shared by the data subject/Policyholder.

Personal data to be processed under the Policy shall be obtained directly from data subjects or indirectly from third parties (family members and representatives, Policyholder, insurance intermediaries, Doctors, Providers, state institutions, and other third parties as authorized to disclose such Personal data).

15.3. Full information about how Personal data shall be processed under the Policy is provided in the Privacy Policy, which can be viewed by clicking on the site terms and conditions at the website www.dhig.net

15.4. The Controller of Personal data of the persons to be insured, Persons Insured and Dependents shall be the Insurer. The contact details of the Insurer are as indicated in the Policy.

15.5. The Coverholder is the processor of Personal data as appointed by the Insurer. The Coverholder is entitled to engage other processors as may be necessary for Processing of Personal data for the purposes as set in paragraph 15.8 of these Rules.

15.6. For the purposes as set in paragraph 15.8 of the Rules, the Personal data may be disclosed to Reinsurers, co-insurers, Medical Consultants, the Assistance Service, other Providers, technical consultants, insurance administration service providers, lawyers, auditors, financial and tax related advisors, banks and fraud investigators, as well as supervising state authorities.

15.7. The contact of the data protection officer: dpo@dhig.net.

15.8. The Personal data is collected by the Coverholder or on its behalf and may be used by the Coverholder and/or persons engaged by it (when acting under the Coverholder's instructions) **for the purposes of** the execution and administration of the Policy (including but not limited to Underwriting and Claims handling), administration of debt recoveries, insurance mediation, research or for statistical purposes, fraud prevention, meeting legal obligations, and arranging redistribution of the insurance risk (for arranging reinsurance and/or co-insurance).

15.9. **Legal grounds** for Processing of Personal data under the Policy may be as follows:

a. Processing is necessary for the performance of the Policy — this shall include such activities as Underwriting, providing the Policyholder with offers/renewal offers/ information about quotation, assessing individual insurance application or health questionnaire completed by the Insured Person/Dependents/ persons to be insured, managing and administrating the Policy, handling Claims, and providing other services to the Insured Persons and Dependents.

b. consent of the data subject/explicit consent of the data subject — this will be relied on (for instance) for Personal data Processing activities related to Processing of health-related Personal data.

c. Processing is necessary for the compliance with legal obligations this will be relied on (for instance) when the Insurer has a legal or regulatory obligation to use such personal information;

d. Processing is necessary in order to protect vital interests of the data subject or another natural person,

e. Processing is necessary for the purpose of legitimate interests — this will be relied on (for instance): (a) when the Insurer has an appropriate business need to process Personal data and such business need does not cause harm to the Insured Person/Dependent. The Insurer will rely on this for activities such as maintaining its business records, developing, improving its insurance products and services related thereto, and providing information about its products and services to the Policyholder and to the Insured Persons; or (b) when the Insurer/the Coverholder needs to use such personal information to establish, exercise or defend Insurer's/Coverholder's legal rights. The Insurer/Coverholder will not use its legitimate interest to process data subject's Personal data when data subject's interests, rights, and freedoms take priority.

15.10. Personal data may be processed both inside and outside of the European Economic Area (EEA) by the parties specified in paragraph 15.6 above, subject always to contractual restrictions regarding confidentiality and security in line with applicable data protection laws and regulations. When transferring Personal data outside EEA, appropriate safeguards for such data transfer (for example, standard data protection clauses as approved by the European Commission) as required by applicable

laws shall be ensured. Personal data will not be disclosed to parties who are not authorized to process them. The Coverholder will not use personal information or pass it on to any other person for the purposes of marketing further products or services without an explicit consent of the data subject.

15.11. Where permitted by applicable law or regulation, the data subject shall have the following rights:

a. to access his/her Personal data to learn the origin of the data, the purposes and ends of the Processing, the details of the data controller(s), the data processor(s), and the parties to whom the data may be disclosed;
b. to withdraw his/her given consent at any time where his/her Personal data is processed based on such a consent;
c. to update or correct his/her Personal data so that it is always accurate;
d. to delete his/her Personal data from the records if it is no longer needed for the purposes indicated above, subject to regulatory Personal data retention requirements;
e. to restrict the Processing of his/her Personal data in certain circumstances, for example where the data subject has contested the accuracy of his/her Personal data, for the period enabling verifying its accuracy;
f. to obtain his/her Personal data in an electronic format;
g. to exercise the right to data portability;
h. to file a complaint to the relevant data privacy authority.

The data subject may exercise his/her rights by contacting the Coverholder at data@dhig.net, while providing his/her name, Policy number, the Policyholder, e-mail address, and the purpose of the request. Where permitted by applicable law or regulation, the data subject shall have the right to object to Processing request stopping Processing of his/her Personal data under the Policy. Under such circumstances, the Processing of Personal data will be stopped, unless permitted by applicable laws and regulations.

15.12. The Personal data collected under the Policy will be retained for a period of time equal to the duration of relevant Policy Period (including any renewals thereof) and for the following 10 years from the date the Policy expires, save for cases where a longer retention period is required for possible disputes, requests of the competent authorities or pursuant to the applicable laws. Once the retention period is over the data will be deleted or anonymized.

15.13. In order to prevent or detect fraud and money laundering, the Coverholder may check personal details with fraud prevention agencies and sanction websites, who may record a search. Searches may also be made against other insurers' databases. If fraud is suspected, information will be shared with those insurers. Other users of the fraud prevention agencies may use this information in their own decision-making processes.

15.14. The Coverholder may also conduct credit reference checks in certain circumstances. Further details can be found in our full Privacy Policy explaining how the information held by fraud prevention agencies may be used.

15.15. The Coverholder may use automated tools with decision-making to assess individual application for insurance or individual health questionnaire and for Claims handling processes. If the Insured Person objects to an automated decision, the Coverholder may not be able to offer the insurance quotation.

15.16. No (re)insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the Republic of Bulgaria, the Slovak Republic, the European Union, the United Kingdom, the United States of America (provided that this does not violate any regulation or specific national law applicable to the undersigned (re)insurer).