

RoamRightSM

VENTURE FARTHER. TRAVEL SMARTER.

**MULTI-TRIP
MEDICAL**

www.roamright.com

877-687-7170

Executive Plaza IV
11350 McCormick Road, Suite 102
Hunt Valley, MD 21031

**DESCRIPTION OF COVERAGE FOR US
RESIDENTS TRAVELING OUTSIDE THE
UNITED STATES**
Underwritten by Arch Insurance Company

**SHORT TERM TRAVEL INSURANCE INCLUDING
EMERGENCY EVACUATION,
REPATRIATION OF REMAINS AND
ACCIDENT AND SICKNESS MEDICAL BENEFITS**

**THIS PROGRAM IS ISSUED FOR A STATED TERM AS
SHOWN IN YOUR SCHEDULE OF COVERAGE AND
SERVICE**

You are not eligible for insurance under the plan until You have enrolled for coverage and paid the appropriate premium and provided You have not already departed on Your Trip.

Policy Number: 21TVL9314200

Individual Short Term Travel Policy Insurance for residents of Colorado, Georgia, Indiana, Kansas, Louisiana, Minnesota, New Hampshire, New York, Ohio, Oregon, South Dakota, Texas, Utah, Washington and Wyoming.

Notice to Residents of Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Wisconsin and West Virginia: The master policy is on file with American Group Travel Trust, BankNewport as Trustee. Your Policy consists of this Description of Coverage, Your Confirmation of Benefits and the enclosed State Exceptions. In the event of any conflict between the Description of Coverage and the master policy, the master policy will govern. If You did not receive any of these documents, please call toll-free: 1-877-687-7170.

SCHEDULE OF COVERAGE AND SERVICE

Maximum Limit for all Benefits - \$100,000 per person per year

Accident and Sickness
Medical Expense Deductible
per Injury or Sickness \$250

Dental Sublimit \$200 /\$25 deductible

Emergency Medical Evacuation /Repatriation Included

Return of Mortal Remains Included

Escort Expense Included

Return of Minor Child Included

Emergency Medical Reunion Included

Worldwide Assistance Services

24/7 Worldwide Assistance Services
Travel Assistance, Medical Emergency, Concierge
Service and Political Evacuation Service

CALL TOLL FREE:

(Within the United States and Canada)

866-443-6971

OR CALL COLLECT:

443-279-7335

(From all other locations)

Optional Coverage

Applicable only when specifically requested on the application and the appropriate additional premium has been paid and purchase confirmed on Your Confirmation of Benefits.

Hazardous Sports Coverage Up to the Accident and Sickness Medical Expense Selected

This Description of Coverage describes all of the travel insurance benefits, underwritten by Arch Insurance Company and herein referred to as the Company. The insurance benefits vary from program to program. Please refer to the Schedule of Coverage and Service as listed above. It provides You with specific information about the program You purchased.

BENEFIT PROVISIONS SCOPE OF COVERAGE

Benefits are payable for the items stated in Your Schedule of Coverage and Service. Benefits shall be payable to either You or the Service Provider for Covered Expenses incurred outside Your Home Country. Coverage is available while traveling to, from and while at Your destination

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

FOURTEEN-DAY LOOK

You may cancel insurance under the policy by giving RoamRight written notice at the address listed on the front panel of this document, within 14 days from the Effective Date of Your initial enrollment. If You do this, the Company will refund Your premium paid provided You have not filed a claim under the policy.

MEDICAL PROTECTION

ACCIDENT AND SICKNESS MEDICAL EXPENSE

The Company will pay Covered Expenses due to Accident or Sickness, as per the limits stated in Your Schedule of Coverage and Service, Accident and Sickness Medical Expense. Coverage is limited to Covered Expenses incurred subject to the Limitations and

Exclusions section. All bodily Injuries sustained in any one Accident shall be considered one Disablement; all bodily disorders existing simultaneously which are due to the same or related causes shall be considered one Disablement. If a Disablement is due to causes which are the same or related to the cause of a prior Disablement (including complications arising there from), the Disablement shall be considered a continuation of the prior Disablement and not a separate Disablement.

Treatment of an Injury or Illness must occur within 30 days of the Accident or onset of the Illness. Illness must manifest itself during the Period of Coverage.

When a covered Injury or Illness is incurred by You, the Company will pay Reasonable and Customary medical expenses of the Deductible and Coinsurance as stated in Your Schedule of Coverage and Service, Accident and Sickness Medical Expense. In no event shall the Company's maximum liability exceed the maximum stated in Your Schedule of Coverage and Service for Accident and Sickness Medical Expense, as to Covered Expenses during any one period of individual coverage.

The Deductible and Coinsurance amount consists of Covered Expenses which would otherwise be payable under the policy. These expenses must be borne by You.

Covered Accident and Sickness Medical Expenses: For the purpose of this section, only such expenses, incurred as the result of a Disablement, which are specifically enumerated in the following list of charges, and which are not excluded in the Limitation and Exclusions section, shall be considered as Covered Expenses:

- 1) Charges made by a Hospital for room and board, floor nursing 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.
- 2) Charges made for diagnosis, Treatment and Surgery by a Physician.

- 3) Charges made for an operating room.
- 4) Charges made for Outpatient Treatment, same as any other Treatment covered on an Inpatient basis. This includes ambulatory Surgical centers, Physicians' Outpatient visits/examinations, clinic care, and Surgical opinion consultations.
- 5) Charges made for the cost and administration of anesthetics.
- 6) Charges for medication, x-ray services, laboratory tests and services, the use of radium and radioactive isotopes, oxygen, blood, transfusions, and medical Treatment.
- 7) Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician.

Accident and Sickness Medical Expense Benefit Period: Only those expenses specifically described above which are incurred within the Benefit Period stated in Your Schedule of Coverage and Service, Accident and Sickness Medical Expense, from the onset of an Injury or Illness and which are not excluded in Limitations and Exclusions section, are considered Covered Expenses. Initial Treatment of an Injury or Illness must occur within 30 days of the Accident or Illness. Illness must first manifest itself during the Period of Coverage.

DENTAL

When covered Dental expenses are incurred by You, the Company will pay Reasonable and Customary expenses in excess of the Deductible and Coinsurance as stated in Your Schedule of Coverage and Service, Dental. In no event shall the Company's maximum liability exceed the maximum stated in Your Schedule of Coverage and Service, Dental, as to Covered Expenses during any one period of individual coverage.

For the purpose of this section, only such expenses, incurred as the result of an eligible Dental condition, in which services or Medications are prescribed, performed, or ordered by a Dentist and enumerated below, and which are not excluded in the Limitations and Exclusions section, shall be considered as Covered Expenses. With respect to Accidental Dental, an eligible Dental condition shall mean emergency dental repair or replacement to

sound, natural teeth damaged as a result of a covered Accident.

EMERGENCY MEDICAL EVACUATION/REPATRIATION

The Company will pay, subject to the limitations set out herein, for Covered Emergency Evacuation Expenses reasonably incurred if You suffer an Injury or Emergency Sickness that warrants Your Emergency Evacuation while covered under the policy. Benefits payable are subject to the Maximum Amount per Insured shown in Your Schedule of Coverage and Service for all Emergency Evacuations due to all Injuries from the same Accident or all Emergency Sicknesses from the same or related causes.

A legally licensed Physician, in coordination with the Assistance Company, must order the Emergency Evacuation and must certify that the severity of Your Injury or Emergency Sickness warrants Your Emergency Evacuation to the closest adequate medical facility. It must be determined that such Emergency Evacuation is required due to the inadequacy of local facilities.

The certification and approval for Emergency Evacuation must be coordinated through the most direct and economical conveyance and route possible, such as air or land ambulance, or commercial airline carrier.

Covered Emergency Evacuation Expenses are those for Medically Necessary Transportation, including Reasonable and Customary medical services and supplies incurred in connection with Your Emergency Evacuation. Expenses for Transportation must be: (a) recommended by the attending Physician; and (b) required by the standard regulations of the conveyance transporting You and (c) reviewed and pre-approved by the Assistance Company.

The Company will also pay reasonable and customary charges, up to the maximum escort limit shown on the Policy, for escort expenses required by You, if You are disabled and an escort is recommended in writing, by the Company's attending Physician and must be pre-approved by the Assistance Company.

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If You are hospitalized for more than 7 days following a Covered Emergency Evacuation Expense, the Company will pay subject to the limitations set out herein, for expenses to return where they reside, with an attendant if necessary, any of Your Dependent Children who were accompanying You when the Injury or Emergency Sickness occurred; but not to exceed the cost of a single one-way economy airfare ticket less the value of applied credit from any unused return travel tickets per person.

Emergency Medical Reunion

When You are hospitalized for more than 7 days, the Company will arrange and pay for round-trip economy-class transportation for one individual selected by You from Your Home Country to the location where You are hospitalized and return to the current Home Country. The benefits payable will include: The cost of a round trip economy air fare up to the maximum stated in Your Schedule of Coverage and Service Emergency Medical Reunion. The period of Emergency Medical Reunion is not to exceed 30 days, including travel.

MEDICALLY NECESSARY REPATRIATION

Following a covered Emergency Evacuation expense or a covered medical expense, the Insurer will pay to return You from the location to which You were evacuated or became sick or injured to Your return destination or the hospital of choice near your primary residence if medically necessary and authorized by the Assistance Company via Common Carrier within one year from Your original Trip completion date.

Commercial airfare costs will be in the same class of service as Your original airline tickets, or in business or first class as in compliance with Your medical necessities and requirements upon Your discharge, less refunds from Your unused transportation tickets.

In addition to the above covered expenses, if the Insurer has previously evacuated You to a medical facility, the Insurer will pay Your airfare costs from that facility to Your primary residence, within one year from Your original Scheduled Return Date, less refunds from Your unused transportation tickets. Airfare costs will be economy, or

first class if Your original tickets are first class. This benefit is available only if it is not provided under another coverage in the policy.

Emergency Evacuation – means Your medical condition warrants immediate transportation from the place where You are injured or sick to the nearest Hospital where appropriate medical treatment can be obtained.

Emergency Sickness - means an illness or disease, diagnosed by a legally licensed Physician, which meets all of the following criteria: (1) there is a present severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of Your condition or places Your life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs while coverage is in force while You suffer the symptom.

Transportation - means any land, sea or air conveyance required to transport You during an Emergency Evacuation. Transportation includes, but is not limited to, Common Carrier, air ambulances, land ambulances and private motor vehicles.

All covered transportation expenses must be approved in advance and arranged by an Assistance Company representative appointed by the Company.

RETURN OF MORTAL REMAINS

The Company will pay the reasonable Covered Expenses incurred to return Your body to Your primary residence if You die while covered under the policy. This will not exceed the maximum stated in Your Schedule of Coverage and Service, Return of Mortal Remains.

Covered Expenses include, but are not limited to, expenses for embalming, cremation, casket for transport and transportation.

All Covered Expenses in connection with a return of mortal remains must be pre-approved and arranged by an

Assistance Company representative appointed by the Company.

TRAVEL ASSISTANCE SERVICES

The Travel Assistance feature provides a variety of travel related services. Services offered include:

24/7 Worldwide Assistance Services
Travel Assistance, Medical Emergency, Concierge
Service and Political Evacuation Service

CALL TOLL FREE:

(Within the United States and Canada)

866-443-6971

OR CALL COLLECT:

443-279-7335

(From all other locations)

AVAILABILITY OF SERVICES

You are eligible for Information and Concierge Services at any time after You purchase this plan. The Emergency Medical, Travel and Evacuation Assistance becomes available when You actually start Your trip. Emergency Assistance, Concierge and Informational Services end the earliest of: midnight on the day the program expires; when You reach Your return destination; or when You complete Your trip.

MEDICAL ASSISTANCE

Medical Monitoring; Medical, Dental, Ophthalmic, and Pharmacy Referrals; Deposits, Advances and Guarantees; Dispatch of Medicine, Eye Glasses, Dental Prosthetics; Emergency Medical Transportation (Evacuation/Repatriation); Medically Supervised Repatriation; Repatriation of Remains.

*Any charges for services rendered will be billed to Your credit card at the time of service.

PRE-TRIP INFORMATION

Required Vaccinations; Health Risks; Travel Restrictions; Weather Conditions (for global destinations worldwide).

CONCIERGE SERVICES

Concierge services are provided by RoamRight's

designated provider. There is no charge for the services provided by the provider. You are responsible for the cost of services provided and charged for by third parties, and for the actual cost of merchandise, entertainment, sports, tickets, food and beverages and other disbursement items. Services offered include: City Profiles; Event Ticketing; Flowers and Gift Baskets; Hotel Accommodations; Meet and Greet Services; Pre-trip Assistance; Restaurant Reviews and Reservations; Rental Car Reservations; Airline Reservations

TRAVEL ASSISTANCE

Translation and Interpreters; Emergency Cash Advance Assistance; Replacement of Lost Traveling Documents Assistance; Emergency Message Forwarding; Lost Luggage Assistance; Legal Referral; Natural Disaster Evacuation Services.

*Any charges for services rendered will be billed to Your credit card at the time of service.

POLITICAL EVACUATION

Political Evacuation is provided by RoamRight's designated provider. In the event of a political emergency situation due to government or social upheaval while traveling in a foreign country; the Assistance Company will evacuate You to the nearest place of safety and then to Your home. All reasonable expenses incurred for Your transportation to the nearest place of safety, and then to Your home, are covered up to a maximum of \$100,000. Arrangements will be by the most appropriate and economical means available and consistent with Your health and safety. If an evacuation is impossible due to hostile conditions, the Assistance Company will use security resources to maintain contact with You until evacuation becomes possible or the emergency is concluded. All arrangements must be arranged and coordinated by the Assistance Company. Services rendered without the coordination and approval of the Assistance Company are not covered.

Travel assistance services are provided by an independent organization and not by Arch Insurance Company or RoamRight. There may be times when circumstances beyond the Assistance Company's control

hinder their endeavors to provide travel assistance services and help You resolve Your emergency situation.

Payment reimbursement to the Assistance Company for non-covered expenses is Your responsibility.

DEFINITIONS

"Accident" or **"Accidental"** shall mean an event, independent of Illness or self inflicted means, which is the direct cause of bodily Injury to You.

"Assistance Company" means the service provider with which the Company has contracted to coordinate and deliver Emergency travel assistance, medical evacuation, and repatriation.

"Benefit Period" means the allowable time period You have from the date of Injury or onset of Illness to receive Treatment for a covered Injury or Illness.

"Child" shall mean Your step-child or a Child under Your legal guardianship, but only if such Child depends on Your support and maintenance and lives with You in a parent-Child relationship. The term Child does not include a foster Child who is eligible for benefits provided by a governmental program or law, unless required by the law of the State.

"Common Carrier" shall mean any land, sea, and/or air conveyance operating under a valid license for the transportation of passenger for hire.

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

"Covered Expenses" shall mean expenses which are for Medically Necessary services, supplies, care, or Treatment; due to Illness or Injury; prescribed, performed or ordered by a Physician; Reasonable and Customary charges; incurred while insured under the policy; and which do not exceed the maximum limits shown in Your Schedule of Coverage and Service, under each stated benefit.

"Deductible" shall mean the amount of eligible Covered Expenses which is Your responsibility and must be paid by You before benefits under the policy are payable by the Company. The Deductible amount is stated in Your Schedule of Coverage and Service, under each stated

benefit.

“Dentist” shall mean 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” shall mean the spouse who is legally married to You; Your unmarried Child from until his/her 19th birthday; or Your unmarried Child who is over 18 years old but not older than 25 years old and is enrolled as a full-time student at an accredited school or college and is not employed on a full-time basis and is dependent on You for his/her support and maintenance. The age limits that apply to Dependent Child(ren) will not apply to Your Child who remains dependent on You for support and maintenance because he or she becomes incapable of working due to a physical handicap or retardation which occurs: before reaching the age limit; and while insured under the policy or any prior plan, provided such Child was insured on the date of termination of the prior plan.

“Disablement” as used with respect to medical expenses shall mean an Illness or an Accidental bodily Injury necessitating medical Treatment by a Physician as defined in the policy.

“Effective Date” shall mean the date Your coverage under the policy begins. The Effective Date is the later of the following: 1. The date the Company receives a completed enrollment form and premium for the Individual Coverage Term; or 2. The moment You exit Your Home Country airspace.

“Emergency” shall mean a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing Your life or limb in danger if medical attention is not provided within 24 hours.

“Experimental/Investigational” means all services or supplies associated with: 1) Treatment or diagnostic evaluation which is not generally and widely accepted in the practice of medicine in the United States of America or which does not have evidence of effectiveness documented in peer reviewed articles in medical journals published in the United States. For the Treatment or diagnostic evaluation to be considered effective such articles should indicate that it is more effective than others available: or if less effective than other available

Treatments or diagnostic evaluations, is safer or less costly; 2) A drug which does not have FDA marketing approval; 3) A medical device which does not have FDA marketing approval; or has FDA approval under 21 CFR 807.81, but does not have evidence of effectiveness for the proposed use documented in peer reviewed articles in medical journals published in the United States. For the device to be considered effective, such articles should indicate that it is more effective than other available devices for the proposed use; or if less effective than other available devices, or is safer or less costly. The company will make the final determination as to whether a service or supply is Experimental/Investigational.

“Family Member” shall mean Your spouse, parent, sibling or Child.

“Home Country” shall mean the country where You have Your fixed and permanent home and principal establishment.

“Hospital” as used in the policy shall mean except as may otherwise be provided, a Hospital (other than an institution for the aged, chronically ill or convalescent, resting or nursing homes) operated pursuant to law for the care and Treatment of sick or Injured persons with organized facilities for diagnosis and Surgery and having 24-hour nursing service and medical supervision means a place that 1.) is legally operated for the purpose of providing medical care and Treatment to sick or injured persons for which a charge is made that You are legally obligated to pay in the absence of insurance 2.) provides such care and Treatment in medical, diagnostic, or surgical facilities on its premises, or those prearranged for its use; 3.) provides 24-hour nursing service under the supervision of a Registered Nurse at all times; and 4.) operates under the supervision of a staff of one or more Doctors. Hospital also means a place that is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, American Osteopathic Association, or the Joint Commission on Accreditation of Health Care Organizations (JCAHO). Hospital does not mean: -a convalescent, nursing, or rest home or facility, or a home for the aged; -a place mainly providing custodial, educational, or rehabilitative care; or -a facility mainly used for the Treatment of drug addicts or alcoholics.

“Host Country” shall mean any country other than the

country where You have Your true, fixed and permanent home and principal establishment.

“Illness” wherever used in the policy shall mean Sickness or disease of any kind and Disablement covered by the policy.

“Incident” or **“Occurrence”** shall mean all Illnesses that exist simultaneously and which are due to the same or related causes are considered to be one Incident. Further, if an Illness is due to causes which are the same as or related to the causes of a prior Illness, the Illness will be deemed to be a continuation of the prior Illness and not a separate Incident. All Injuries due to the same Accident shall be deemed to be one Incident.

“Individual Coverage Term” means the period of time beginning when You have been enrolled for coverage under the policy and for whom the required premium has been paid and ending on the termination date as described in the Schedule of Coverage and Service.

“Injury” wherever used in the policy means Accidental bodily Injury or injuries caused by an Accident. The Injury must be the direct cause of the Loss, independent of disease, bodily infirmity or other causes. Any Loss due to Injury must begin after the Effective Date of the policy.

“Inpatient” means You are confined in an institution and is charged for room and board.

“Insured Person(s)” shall mean a person who has applied for coverage and is named on the Confirmation of Benefits and for whom the Company has accepted premium. Insured Persons are also referred to as You and Your.

“Land/Sea Arrangements” means land and or sea arrangements made by Travel Supplier.

“Loss” in reference to quadriplegia, paraplegia, hemiplegia, and uniplegia, shall mean the complete and irreversible paralysis of such limbs and with regard to hands and feet, actual severance through and above the wrist or ankle joints, and with regard to eyes, entire irrecoverable Loss of sight and with regard to thumb and index finger, actual severance through or above the joint that meets the finger at the palm. Loss in reference to other coverages shall mean injury or damage sustained by You in consequence of happening of one or more of the accidents against which the Company has undertaken to indemnify You.

“Maximum Benefit” means the largest total amount of Covered Expenses that the Company will pay for You.

“Medically Necessary” or **“Medical Necessity”** shall mean services and supplies received by You that are determined by the Company to be: 1) appropriate and necessary for the symptoms, diagnosis, or direct care and Treatment of Your medical conditions; 2) within the standards the organized medical community deems good medical practice for Your condition; 3) not provided solely for educational purposes or primarily for Your convenience, Your Physician or another Service Provider or person; 4) not Experimental/Investigational or unproven, as recognized by the organized medical community, or which are used for any type of research program or protocol; and 5) not excessive in scope, duration, or intensity to provide safe and adequate, and appropriate Treatment. For Hospital stays, this means that acute care as an Inpatient is necessary due to the kinds of services You are receiving or the severity of Your condition, in that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The fact that any particular Physician may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such Treatment Medically Necessary or make the charge of a Covered Expense under the policy.

“Medicine” or **“Medications”** shall mean the drugs prescribed or dispensed to You, by a licensed Physician, as a result of a Covered Expense. Medicine or Medication shall mean the generic equivalent of a drug, or if the generic equivalent is not available, the brand name drug.

“Mental and Nervous Disorder” shall mean any condition or disease listed in the most recent edition of the International Classification of Diseases as a mental disorder, which exhibits clinically significant behavioral or psychological disorder marked by a pronounced deviation from a normal healthy state and associated with a present painful symptom or impairment in one or more important areas of functioning. This disease must not be merely an expectable response to a particular stimulus. Mental Illness does not mean learning disabilities, attitudinal disorders or disciplinary problems.

“Outpatient” shall mean You receive care in a

Hospital or another institution, including; ambulatory surgical center; convalescent/skilled nursing facility; or Physician’s office, for an Illness or Injury, but who is confined and is not charged for room and board.

“Permanent Residence” shall mean the country where You have Your fixed and permanent home and principal establishment, and to which You have the intention of returning.

“Physician” as used in the policy shall mean a doctor of medicine or a doctor of osteopathy licensed to render medical services or perform Surgery in accordance with the laws of the jurisdiction where such professional services are performed, however, such definition will exclude chiropractors and physiotherapists.

“Pre-existing Condition” for the purposes of the policy shall mean 1) a condition that would have caused a person to seek medical advice, diagnosis, care or Treatment during the 6 months prior to the Effective Date of coverage under the policy; 2) a condition for which medical advice, diagnosis, care or Treatment was recommended or received during the 180 days prior to the Effective Date of coverage under the policy. Sickesses or conditions are not considered pre-existing if the Sickness or condition for which prescribed drugs or medicine is taken remains controlled without any change in the required prescription.

“Prior Plan” shall mean the coverage provided on a group or individual basis by an insurance policy benefit plan or service plan that was terminated on the day before Your Effective Date of coverage under that policy and replaced by this policy.

“Reasonable and Customary” shall mean the maximum amount that the Company determines is Reasonable and Customary for Covered Expenses You receive up to but not to exceed charges actually billed. The Company’s determination considers: 1) amounts charged by other Service Providers for the same or similar service in the locality were received, considering the nature and severity of the bodily Injury or Illness in connection with which such services and supplies are received; 2) any usual medical circumstances requiring additional time, skill or experience; and 3) other factors the Company determines are relevant, including but not limited to, a resource based relative value scale.

For a Service Provider who has a reimbursement agreement, the Reasonable and Customary charge is equal to the amount that constitutes payment in full under any reimbursement agreement with the Company.

If a Service Provider accepts as full payment an amount less than the negotiated rate under a reimbursement agreement, the lesser amount will be the maximum Reasonable and Customary charge.

The Reasonable and Customary charge is reduced by any penalties for which a Service Provider is responsible as a result of its agreement with the Company.

“Registered Nurse” shall mean a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other jurisdictional authority, and who is legally entitled to place the letters “R.N.” after his or her name.

“Relative” shall mean Your spouse, parent, sibling, Child, grandparent, grandchild, step-parent, step-child, step-sibling, in-laws (parent, son, daughter, brother and sister), aunt, uncle, niece, nephew, legal guardian, ward, or cousin.

“Scheduled Departure Date” means the date on which You are originally scheduled to leave on the Trip.

“Scheduled Return Date” means the date on which You are originally scheduled to return to the point of origin or to a different final destination.

“Service Provider” shall mean a Hospital, convalescent/skilled nursing facility, ambulatory surgical center, psychiatric Hospital, community mental health center, residential Treatment facility, psychiatric Treatment facility, alcohol or drug dependency Treatment center, birthing center, Physician, Dentist, chiropractor, licensed medical practitioner, Registered Nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility that the Company approves.

“Sickness” means Illness or disease contracted and causing Loss commencing while coverage under the policy is in force as You whose Sickness is the basis of claim. Any complication or any condition arising out of a

Sickness for which You are being treated or has received Treatment will be considered as part of the original Sickness.

"Surgery" shall mean an invasive diagnostic procedure; or the Treatment of Illness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.

"Terrorism" is defined as the systematic or planned use of violence, fear, or threat of violence in order to intimidate a population or government, especially as a means of coercion or to obtain a granting of any demand. Terrorism does not include an event in any country or location where the United States government has issued a travel advisory that has been in effect within the 6 months prior to Your date of arrival. Terrorism does not include an event that occurs after a travel advisory has been issued after Your arrival date, and where You unreasonably fail or refuse to depart the location.

"Terrorist Attack" means an incident deemed an act of terrorism by the United States Government.

"Travel Supplier" means tour operator, cruise line, hotel etc. who has made the land and/or sea arrangements.

"Treatment" means a specific in-office or Hospital physical examination of, care rendered to You.

"Trip" means any trip taken during the Individual Coverage Term. Maximum Trip duration is 30 days Coverage is available for persons under age (80).

"Unexpected" means not anticipated or expected and occurring after the effective date of the Policy.

LIMITATIONS AND EXCLUSIONS

Excess Benefits: All coverages, shall be in excess of all other valid and collectible Insurance Indemnity and shall apply only when such benefits are exhausted.

The following exclusions apply. This policy does not cover Loss caused by or resulting from:

1. Pre-Existing conditions, defined in the policy. This exclusion does not apply to Emergency Evacuation/Repatriation;
2. Suicide or attempt thereof by You or self destruction or any attempt thereof by You;

3. Injury sustained while You are riding as a pilot, student pilot, operator or crew member, in or on, boarding or alighting from, any type of aircraft;
4. War, invasion, acts of foreign enemies, hostilities between nations(whether declared or not), civil war;
5. Service in the military, naval or air service of any country; participation in any military maneuver or training exercise;
6. Being under the influence of alcohol or having taken drugs or narcotics unless prescribed by a legally qualified Physician or surgeon; Treatment in connection with alcoholism and drug addiction, or use of any drug or narcotic agent;
7. Injury occasioned or occurring while You are committing or attempting to commit a felony or to which a contributing cause was You being engaged in an illegal occupation;
8. Pregnancy, childbirth, miscarriage or abortion;
9. Charges for treatment which is not Medically Necessary;
10. Charges provided at no cost to You;
11. Charges for treatment which exceed Reasonable and Customary charges;
12. Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes;
13. Services, supplies or treatment, including any period of Hospital confinement, which were not recommended, approved and certified as Medically Necessary and reasonable by a Physician;
14. Injury sustained while participating in professional athletics;
15. Routine physicals, immunizations or other examinations where there are no objective indications or impairment in normal health, and laboratory diagnostic or x-ray examinations, except in the course of a Disablement established by a prior call or attendance of a Physician unless otherwise covered under the policy.
16. Services or supplies performed or provided by Your Relative, or anyone who lives with You;
17. Travel arrangements that were neither coordinated by nor approved by the Assistance Company in advance;
18. Cosmetic or plastic Surgery, except as the result of a covered Accident; for the purposes of the policy, treatment of a deviated nasal septum shall be considered a cosmetic condition;
19. Elective Surgery which can be postponed until You return to Your Home County, where the objective of the trip is to seek medical advice, treatment or Surgery; travel after Your Physician has limited or restricted travel;
20. Treatment and the provision of false teeth or dentures, normal ear tests and the provision of hearing aids;
21. Eye refractions or eye examinations for the purpose of prescribing corrective lenses for eye glasses or for the fitting thereof, unless caused by Accidental bodily Injury incurred while insured hereunder;
22. Treatment for any Mental and Nervous Disorders;
23. Injury sustained while taking part in mountaineering where ropes or guides are normally used; hang gliding, parachuting, bungee jumping, snowmobiling, jet skiing, scuba diving involving underwater breathing apparatus, unless PADI or NAUI certified, water skiing, snow skiing, spelunking, parasailing, snowboarding, extreme skiing, bodily contact sports, skydiving, any race or speed contest;
24. Dental care, except as the result of Injury to natural teeth caused by Accident;

Hazardous Sport Coverage: the following are covered if the required premium has been paid: mountaineering where ropes or guides are normally used (15,000 feet limit); parachuting, bungee jumping, snowmobiling, scuba diving involving underwater breathing apparatus; jet skiing, water skiing, snow skiing, spelunking, and snowboarding;

CLAIMS PROCEDURE

To facilitate prompt claims settlement:

MEDICAL EXPENSES: Obtain receipts from the providers of service, etc., stating the amount paid and

listing the diagnosis and treatment. Submit these first to other medical plans. Provide a copy of their final disposition of Your claim.

HOW TO CONTACT US TO FILE A CLAIM:

Arch Insurance Company
Executive Plaza IV
11350 McCormick Road, Suite 102
Hunt Valley, MD 21286
PHONE: 1-855-762-6252
FAX: 443-279-2901
EMAIL: claims@roamright.com
WEBSITE: www.roamright.com

GENERAL PROVISIONS

Conformity With State Statues: Any provision of the Policy which, on its effective date, is in conflict with the statues of the state in which the Policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statues.

Individual Period of Coverage: Your coverage is in effect for a stated term as shown on the Schedule of Coverage and Service. The insurance is not renewable.

When Your Coverage Begins: All coverage will take effect at 12:01 A.M. local time, at Your location, on the latest of the following: 1. coverage has been elected and 2. the required premium has been paid.

When Your Coverage Ends: Individual coverage will terminate upon the earlier of the following: 1. The moment You return to Your Home Country, unless otherwise covered under Your policy. The insurance does not renew.

Assignment: The Insurance provided hereunder is not assignable, but benefits may be assigned in accordance the Payment of Claims provision.

Renewal of Individual Insurance: The initial Period of Coverage cannot exceed twelve (12) months.

Not in Lieu of Worker's Compensation: The Policy is not in lieu of and does not affect any requirements for coverage by Worker's Compensation Insurance.

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Monetary Limits: The monetary limits stated in the policy and the premium shall be in U.S. dollars. For service outside of the territorial limits of the United States, the exchange rate date used to determine the amount of U.S. dollars to be paid is the exchange rate effective for the date the claims expense was incurred.

Subrogation: To the extent the Company pays for a loss suffered by You, the Company will take over the rights and remedies You had relating to the loss. This is known as subrogation. You must help the Company to preserve its rights against those responsible for the loss. This may involve signing any papers and taking any other steps the Company may reasonable require. If the Company takes over Your rights, You must sign an appropriate subrogation form supplied by the Company.

STATE EXCEPTIONS

ALASKA RESIDENTS:

The exclusion related to terrorism is deleted.

The following is added to the **GENERAL PROVISIONS** section:

EXAMINATION UNDER OATH: You are allowed to have legal representation present when examined under oath.

INSURANCE WITH OTHER INSURERS: If You have other valid coverage, for which this Company has not been given written notice prior to the occurrence or commencement of a Loss, the Company's liability, under any expense incurred coverage of this policy, shall be for such proportion of the Loss as the amount which would otherwise have been payable under this policy plus the total of the like amounts under all such other valid coverages for the same Loss of which You had notice bears to the total like amounts under all valid coverages for such Loss. The Company shall return such portion of the premiums paid as shall exceed the pro-rata portion for the Company's liability as so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such

coverage.

LEGAL ACTIONS: No actions at law or in equity shall be brought to recover on the policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with requirements of this policy. No such action shall be brought after expiration of three years after that time written Proof of Loss is required to be furnished.

Regarding Claims payments, undisputed claims will be paid within 30 business days of satisfactory notice of loss.

CONNECTICUT RESIDENTS:

The following replaces the **DESCRIPTION OF COVERAGE SECTION** on page 1:

THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A LIMITED BENEFITS TRAVEL POLICY THAT INCLUDES SHORT TERM TRAVEL INSURANCE INCLUDING TRIP INTERRUPTION, BAGGAGE/PERSONAL EFFECTS, EMERGENCY EVACUATION, REPATRIATION OF REMAINS, ACCIDENTAL DEATH AND DISMEMBERMENT, ACCIDENT MEDICAL BENEFITS AND SICKNESS MEDICAL EXPENSES AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE LISTED IN YOUR SCHEDULE OF COVERAGE.

THIS PROGRAM IS ISSUED FOR A STATED TERM AS SHOWN IN YOUR SCHEDULE OF COVERAGE AND SERVICE

The definition of **Experimental/Investigational** is amended by the addition of the following:

Experimental/Investigational does not include a procedure, Treatment or the use of any drug as experimental if such procedure, Treatment or drug, for the illness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a phase III clinical trial of the federal Food and Drug Administration.

The definition of **Medically Necessary** is deleted in its entirety and replaced with the following:

“Medically Necessary” or **“Medical Necessity”** means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, Injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, Injury or disease; and (3) not primarily for the convenience of the patient, Physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or Treatment of that patient's illness, Injury or disease. For the purposes of this definition, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

The following revisions apply to the **LIMITATIONS AND EXCLUSIONS** section:

Exclusion 4b. is amended to delete the word “riot”.

The following Exclusions are deleted in their entirety:

10. While riding or driving in any kind of competition;

17. Injury sustained while participating in professional athletics;

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Exclusion 8 is amended as follows:

8. Loss caused by the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by a physician;

Exclusion 30. is amended as follows:

30. Injury sustained while taking part in hang gliding and parachuting. **Hazardous Sport Coverage:** The following are covered if the required premium has been paid: hang gliding and parachuting;

The following revisions apply to the **GENERAL PROVISIONS** section:

Appeals

If Your medical claim is denied in whole or in part by the Company based on Medical Necessity or refusal by the Company to pre-certify, You may appeal the denial to the Commission of Insurance. Your appeal to the Commissioner must be made within sixty (60) days of Your receipt of the Company's final written notice of denial. Your written appeal must be submitted on forms provided by and prescribed by the Department of Insurance and must include a general release, executed by You, of all pertinent medical records and a filing fee of twenty-five dollars (\$25). The decision by the Department of Insurance is final and binding.

Subrogation

The Subrogation provision is deleted in its entirety.

The **EXCESS INSURANCE LIMITATION** is deleted in its entirety wherever it appears in this Description of Coverage.

ILLINOIS RESIDENTS:

The definition of Injury is amended to read:

“Injury” means Accidental bodily Injury or injuries

caused by an Accident. The Injury must be the direct cause of the Loss, independent of disease or bodily infirmity. Any Loss due to Injury must begin after the Effective Date of the policy.

Exclusion 4 is deleted in its entirety and replaced with the following:

4. Any consequence, arising in connection with: a) war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war; b) mutiny, riot, strike, military or popular uprising insurrection, rebellion, revolution, military or usurped power.

Exclusion 9 is deleted in its entirety and replaced with the following:

9. Injury occasioned or occurring while You are committing or attempting to commit a felony or while You were engaged in an illegal occupation;

Exclusion 26. is deleted in its entirety and replaced with the following:

26. Injury sustained while under the influence of or Disablement due to the effects of intoxicating liquor or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician for a condition which is covered hereunder but not for the Treatment of drug addiction. Intoxication is that which is defined and determined by the laws of the State where the Loss or cause of Loss was incurred;

The following is added to the **GENERAL PROVISIONS** section:

The Company will affirm or deny liability for any claim filed under this policy within a reasonable amount of time. After the amount of the claim is determined and if the claim is not in dispute, the Company will make payment within 30 days.

If the amount of a claim payment is less than the amount claimed or if a claim is denied, the Company shall provide You with a reasonable written explanation of their action

within 30 days after the claim investigation and determination is completed.

LOUISIANA RESIDENTS:

The following is added to the **GENERAL PROVISIONS** section:

Claims will be paid within 30 days of satisfactory proof of loss is received by the Company or its agent.

MICHIGAN RESIDENTS:

The following is added to the **GENERAL PROVISIONS** section:

You must advise the Company or its agent as soon as reasonably possible in the event of a claim. The Company will not pay benefits for any additional charges incurred that would not have been charged had You notified the Company or its agent in a timely manner unless it shall be shown not to have been reasonably possible to give such notice in a timely manner and that notice was given as soon as was reasonably possible.

MINNESOTA RESIDENTS:

The provision entitled "Subrogation" is amended to read:
Subrogation: To the extent the Company pays for a loss suffered by You, the Company will take over the rights and remedies You had relating to the loss. This is known as subrogation. You must help the Company to preserve its rights against those responsible for the loss. This may involve signing any papers and taking any other steps the Company may reasonably require. If the Company takes over Your rights, You must sign an appropriate subrogation form supplied by the Company. The Company's rights do not apply against any person insured under this or any other policy/coverage part the Company issues with respect to the same occurrence or loss.

The exclusion related to drug use and intoxication is amended to read:

26. Injury sustained while under the influence of or

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Disablement due to wholly or partly to the effects of intoxicating liquor or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician for a condition which is covered hereunder to the extent that a person was operating a motor vehicle;

The terrorism exclusion does not apply.

MISSOURI RESIDENTS:

The definition of "Accident" is amended to read:
"Accident" or **"Accidental"** shall mean an event, independent of illness or self inflicted means while insane, which is the direct cause of bodily injury to You.

The definition of "Dependent" is amended to read:
"Dependent" shall mean the spouse who is legally married to You; Your unmarried Child from birth until his/her 25th birthday. The age limits that apply to Dependent Child(ren) will not apply to any insured Child of Your who remains dependent on You for support and maintenance because he or she becomes incapable of working due to a physical handicap or retardation which occurs: before reaching the age limit; and while insured under the policy or any prior plan, provided such Child was insured on the date of termination of the prior plan.

The definition of "Injury" is amended to read:
"Injury" wherever used in the policy shall mean bodily injury resulting directly and independently of all other causes in Disablement covered by the policy. Injury also means accidental bodily injury or injuries caused by an accident. The Injury must be the direct cause of the loss, independent of disease, bodily infirmity or other causes. Any loss due to Injury must begin after the Effective Date of the policy.

Exclusion 2. Suicide is deleted in its entirety.

Exclusion 11. Pregnancy is deleted in its entirety.

Any exclusions related to terrorism are deleted in their entirety.

The **GENERAL PROVISIONS** section is amended by the addition of the following provision:

Proof of Loss: Within ninety (90) days of the Company or its agent's request, You or Your representative must provide any requested proof of loss. Notwithstanding, no claim will be denied based on such person's failure to provide notice within such specified time, unless this failure operates to prejudice the Company's rights. Any provisions that conflict with this provision are deleted.

Underwritten by Arch Insurance Company
Arch Insurance Company
300 Plaza Three
Jersey City, NJ 07311
1-855-762-6252

MONTANA RESIDENTS:

The **Conformity With State Statutes** is amended to read:

Conformity with Montana Statutes: The provisions of this description of coverage conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which You reside on or after the effective date of this description of coverage.

With regard to Montana residents, Sickness includes pregnancy and childbirth and any exclusions related specifically to pregnancy or childbirth are deleted.

NEW HAMPSHIRE RESIDENTS:

The policy title has been amended to the following:

**INDIVIDUAL SHORT TERM TRAVEL POLICY
INSURANCE
Limited Benefit Health Coverage**

The definition of Dependent has been amended to the following:

"Dependent" means: 1. The spouse who is legally married to You or partners to a civil union; and/or 2. Your Child by blood or by law who: a. is less than 26 years old;

b. is unmarried; c. is a resident of New Hampshire or is enrolled as a student at a public or private institution of higher education; and d. is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, Public Law 89-97, 42 U.S.C. 1395 et seq.

The definition of Domestic Partner has been amended to the following:

“Domestic Partner” means a person, at least 18 years of age, with whom you have been living in a spousal relationship with evidence of cohabitation for at least 10 continuous months prior to the Effective Date of coverage or partners to a civil union.

The definition of Emergency has been amended to the following:

“Emergency” shall mean a medical condition manifesting itself by acute signs or symptoms which could reasonably result in any of the following:

1. Serious jeopardy to the patient’s health.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

The definition of Family Member has been amended to the following:

“Family Member” shall mean a spouse, partners to a civil union, parent, sibling or Your Child.

Exclusion 8. has been amended to the following:

Exclusion 8. Driving while legally intoxicated or having taken illegal drugs or narcotics, unless prescribed by a legally qualified Physician or surgeon;

The **GENERAL PROVISIONS** section has been amended to include the following provisions:

Notice of Claim: Written notice of sickness or of injury must be given to the Company or its agent within 20 days

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after the date when such sickness or injury occurred.

Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.


Claim Forms: The Company or its Agent will furnish You such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after the Company or its agent receives notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Proof of Loss: Written proof of such loss must be furnished to the Company or its agent within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible. In any case, the proof required must be given no later than one year from the time specified except in the absence of legal capacity.

Time of Payment of Claim: All benefits payable under the policy will be payable not more than 60 days after receipt of satisfactory proof of loss. Benefits will be paid to You or, in the case of Your death, to your estate.

Physical Examination and Autopsy: The Company shall have the right and opportunity to examine You when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law. These will be at the Company’s expense.

Signature of Authorized Agent has been added:



Linda Fallon
SVP, Travel

Authorized Agent

NEW YORK RESIDENTS:

The definition of Hospital is amended to read:

“Hospital” means a short-term, acute, general hospital, that:

- (a) is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- (b) has organized departments of medicine and major surgery;
- (c) has a requirement that every patient must be under the care of a physician or dentist;
- (d) provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- (e) if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97, (42 USCA 1395xk);
- (f) is duly licensed by the agency responsible for licensing such hospitals; and is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

The definition of Pre-existing Condition is amended to read:

“Pre-existing Condition” for the purposes of the policy shall mean a condition that would have caused a person to seek medical advice, diagnosis, care or Treatment during the 6 months prior to the Effective Date of coverage under the policy.

The following is added to the medical expense benefits:

NEW YORK MANDATES: Under New York Law, certain mandated benefits are required to be provided under a medical expense policy. The Company will pay benefits

as applicable to this program for such mandates.

The section titled **LIMITATIONS AND EXCLUSIONS** is amended as follows:

Exclusion 2. is amended to read: Suicide or attempt thereof by You while sane or intentional destruction or any attempt thereof You while insane;

Exclusion 4 a-d related to war, mutiny, terrorism, or martial law is amended to read:
War or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the Armed Forces or units auxiliary thereto;

Exclusion 9. is deleted.

Exclusion 10. related to riding or driving in a competition is amended to read:
While riding or driving in any kind of competition in a professional capacity;

Exclusion 11. related to pregnancy is revised to read:
Pregnancy, childbirth, or miscarriage except for complications therefrom;

The following exclusion is added:
25. Abortion.

The exclusions for all other benefits are amended as follows:
Exclusion 1 related to Pre-existing Conditions is amended to read:
Pre-existing Conditions, defined in the policy for 12 months following the Effective Date of coverage. For the purpose of this exclusion, genetic information shall not be treated as a Pre-existing Condition in the absence of a diagnosis of the condition related to such information. No Pre-existing Condition limitation provision shall exclude coverage in the case of:

(1) an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage as defined in subsection (c) of this

section;

(2) a Child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage as defined in subsection (c) of this section;

(3) pregnancy; or

(4) an individual, and any dependent of such individual, who is eligible for a federal tax credit under the federal Trade Adjustment Assistance Reform Act of 2002 {Footnote 1} and who has three months or more of creditable coverage;

Exclusion 12. related to treatment which is not medically necessary is removed.

Exclusion 21. related to cosmetic or plastic surgery is amended to read:
Cosmetic Surgery or plastic surgery, except that Cosmetic Surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent Child which has resulted in a functional defect;

Exclusion 25. related to alcoholism and drug addition is amended to read:
Treatment in connection with alcoholism and drug addiction, or use of any drug or narcotic agent, except to the extent otherwise covered under the policy;

Exclusion 27. related to Mental and Nervous Disorders is amended to read:
Treatment for any Mental and Nervous Disorder, except to the extent otherwise covered under the policy;

The following provisions are added to the **GENERAL PROVISIONS** section:

NOTICE OF CLAIM. Written notice of claim must be given by the Claimant (either You or someone acting for You) to the Company or its designated representative within twenty (20) days after a covered loss first begins or as soon as reasonably possible. Notice should include Your name and the policy number. Notice should be sent to the Company's administrative office, at the address shown on the cover page of the policy, or to the Company's designated representative.

PROOF OF LOSS. The Claimant must send the Company, or its designated representative, proof of loss within ninety (90) days after a covered Loss occurs or as soon as reasonably possible.

PAYMENT OF CLAIMS. The Company, or its designated representative, will pay a claim after receipt of acceptable proof of loss. Benefits are payable to You unless You are not alive. If You are not alive benefits will be payable to Your estate. All or a portion of all other benefits provided by this policy may, at the option of the Company, be paid directly to the provider of the service(s). All benefits not paid to the provider will be paid to You. Any payment made in good faith will discharge the Company's liability to the extent of the claim.

PHYSICAL EXAMINATION AND AUTOPSY. The Company, or its designated representative, at their own expense, have the right to have You examined as often as reasonably necessary while a claim is pending. The Company, or its designated representative, also have the right to have an autopsy made unless prohibited by law.

Subrogation is replaced with the following:

To the extent the Company pays for a Loss suffered by You, the Company will take over the rights and remedies You had relating to the Loss against the party responsible for Your Illness or Injury to the extent of the benefits the Company has paid. This means that the Company has the

right independently of You to proceed against the party responsible for your Illness or Injury to recover the benefits we have paid.

The Excess Benefits provision is deleted in its entirety.

NORTH CAROLINA RESIDENTS:

The following changes are made to the **DEFINITIONS** section:

The definition of "Child" is revised to read:

"Child" shall mean Your step-child or a Child Your legal guardianship, but only if such Child depends on You for support and maintenance. The term Child includes a foster Child who is eligible for benefits provided by a governmental program or law, to the extent required by North Carolina law.

A definition of "Complications of Pregnancy" is added:

"Complications of Pregnancy" means: (1) conditions requiring hospital stays (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, and (2) non-elective caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

The definition of "Dependent" is revised to read:

"Dependent" shall mean the spouse who is legally married to You; Your unmarried natural Child from birth, foster child from the date the child is placed in Your home, or adopted child from date of adoption until his/her 19th birthday; or Your unmarried Child who is over 18 years old but not older than 23 years old and is enrolled as a full-time student at an accredited school or college and is not employed on a full-time basis and is dependent on You for his/her support and maintenance. The age limits that apply to Your Dependent Child(ren) will not apply to any insured Child who remains dependent on You for support and maintenance because he or she becomes incapable of working due to a physical handicap or retardation which occurs: before reaching the age limit; and while insured under the policy or any prior plan,

provided such Child was insured on the date of termination of the prior plan.

The definition of "Hospital" is revised to read:

"Hospital" as used in the policy shall mean except as may otherwise be provided, a Hospital (other than an institution for the aged, chronically ill or convalescent, resting or nursing homes) operated pursuant to law for the care and Treatment of sick or Injured persons with organized facilities for diagnosis and having 24-hour nursing service and medical supervision.

Hospital also means:

1. a place that is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, American Osteopathic Association, or the Joint Commission on Accreditation of Health Care Organizations (JCAHO). 2. A duly licensed State tax-supported institution, including those providing services for medical care of cerebral palsy, other orthopedic and crippling disabilities, mental and nervous diseases or disorders, mental retardation, alcoholism and drug or chemical dependency, and respiratory illness, on a basis no less favorable than the basis which would apply had the medical care been rendered in or by any other public or private institution or provider.

The term "State tax-supported institutions" shall include community mental health centers and other health clinics which are certified as Medicaid providers. Hospital does not mean: -a convalescent, nursing, or rest home or facility, or a home for the aged; -a place mainly providing custodial, educational, or rehabilitative care.

The definition of "Pre-Existing Condition" is revised to read:

"Pre-existing Condition" for the purposes of the policy shall mean 1) a condition that would have caused a person to seek medical advice, diagnosis, care or Treatment during the 12months prior to the Effective Date of coverage under the policy; 2) a condition for which medical advice, diagnosis, care or Treatment was recommended or received during the 12 months prior to the Effective Date of coverage under the policy.

The following changes are made to the Exclusion section:

Exclusion 1. is revised to read:

1. Pre-Existing conditions, defined in the policy for the 12 consecutive months following the policy inception date. This exclusion does not apply to Emergency Evacuation/Repatriation. Credit for having satisfied some or all of the preexisting waiting period under previous health benefits is provided to the extent mandated by North Carolina law,

Exclusion 4. is revised to exclude war, whether declared or not declared. All exclusion sections related to terrorism as defined in this document are deleted,

Exclusion 11. is revised as follows:

11. Pregnancy, except for Complications of Pregnancy, childbirth, miscarriage or abortion;

The following change is made to the **GENERAL PROVISIONS** section:

The Subrogation clause is eliminated.

NORTH DAKOTA RESIDENTS:

The definition of "Dependent" is replaced in its entirety with the following:

"Dependent" shall mean the spouse who is legally married to You; Your unmarried Child from birth until his/her 22nd birthday; or Your unmarried Child who is over 22 years old but not older than 26 years old and is enrolled as a full-time student at an accredited school or college and is not employed on a full-time basis and is dependent on You for his/her support and maintenance. The age limits that apply to Your Dependent Child(ren) will not apply to any insured Child who remains dependent on You for support and maintenance because he or she becomes incapable of working due to a physical handicap or retardation which occurs: before reaching the age limit; and while insured under the policy or any prior plan, provided such Child was insured on the date of

termination of the prior plan.

OKLAHOMA RESIDENTS:

The following is **FRAUD STATEMENT** is added to the **GENERAL PROVISIONS** section:

Warning: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of felony.

The following changes made to the **DEFINITIONS** section:

The definition of "Child is revised to read:

"Child" shall mean Your step-child or a Child under Your legal guardianship, but only if such Child depends on You for support and maintenance. The term Child does not include a foster Child who is eligible for benefits provided by a governmental program or law, unless required by the law of the State.

The definition of "Dependent" is revised to read: **"Dependent"** shall mean the spouse who is legally married to You; Your unmarried Child from birth until his/her 19th birthday; or Your unmarried Child who is over 19 years old but not older than 23 years old and is enrolled as a full-time student at an accredited school or college and is not employed on a full-time basis and is dependent on You for his/her support and maintenance. Subject to the age limits stated above, and subject to providing the Company with written notice within 31 days of obtaining custody, a Dependent Child also means Your adopted Child from the date the Child is placed in Your custody and/or a Child in Your temporary care pursuant to an interlocutory decree issued under Title 10 of the Oklahoma statutes during the pendency of an adoption proceeding regardless of whether a final decree of adoption is ultimately issued. The age limits that apply to Your Dependent Child(ren) will not apply to any insured Child who remains

dependent on You for support and maintenance because he or she becomes incapable of working due to a physical handicap or retardation which occurs: before reaching the age limit; and while insured under the policy or any prior plan, provided such Child was insured on the date of termination of the prior plan.

The definition of "Physician" is revised to read: **"Physician"** as used in the policy shall mean a person holding a valid license to practice medicine and surgery, osteopathic medicine, chiropractic, podiatric medicine, optometry or dentistry in accordance with the laws of the jurisdiction where such professional services are performed, however, such definition will exclude physiotherapists.

The following definition is added:

"Domestic Partner": Domestic Partner means a person who is at least 18 years of age and You can show: 1) evidence of financial interdependence, such as joint bank accounts or credit cards, jointly owned property, and mutual life insurance or pension beneficiary designations; 2) evidence of cohabitation for at least the previous 6 months; and 3) an affidavit of domestic partnership if recognized by the jurisdiction within which they reside.

The following changes are made to the **LIMITATIONS AND EXCLUSIONS** section:

Exclusion 4 (a) – 7 (d) is amended to read: war or any act of war, whether declared or undeclared while serving in military service or any auxiliary thereto;

The following changes are made to the **GENERAL PROVISIONS** section:

The **EXCESS BENEFITS** Provision is deleted and the following is added:

When other benefits are available for the same Loss, the order of payment for this policy and other policies in

effect shall be in accordance with the coordination of benefits rules established by Oklahoma Administrative Code.

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty days after the Company receives written proof of loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving written proof of loss.

OREGON RESIDENTS:

The following changes are made to the policy:

1. Any exclusions related to terrorism or terrorist acts are deleted in their entirety. The exclusion related to imposing a time limit for submitting claims are deleted and governed by the Proof of Loss Provision that follows.
2. The **GENERAL PROVISIONS** section is amended by the addition of the following provisions:

NOTICE OF CLAIM: Written notice of claim must be given by the claimant (either You or someone acting on Your behalf) to the Company or its designated representative within fifteen (15) days after a covered Loss first begins or as soon as reasonably possible. Notice should include Your name and the Plan Number. Notice should be sent to the Company or to the Company's designated representative.

PROOF OF LOSS: The claimant must send the Company, or its designated representative, proof of loss within ninety (90) days after a covered Loss occurs or as soon as reasonably possible but not longer than 12 months unless you were legally incapacitated.

3. The definition of **"Family Member"** is revised to include Domestic Partner. A Domestic Partnership means a civil contract entered into in person

between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident Oregon.

PENNSYLVANIA RESIDENTS:

Individual Period of Coverage is revised to state:

Individual Period of Coverage: You coverage is in effect for a stated term as shown on the Schedule of Coverage and Service.

SOUTH CAROLINA RESIDENTS:

Under section **GENERAL PROVISIONS**, the following provisions are added:

Physical Examinations and Autopsy: The Company has the right to physically examine You as often as reasonably needed while a claim is pending. In case of death, the Company may also have an autopsy performed during the period of contestability unless prohibited by law. The autopsy must be performed in South Carolina. The Company will bear all costs for these.

Legal Actions: No legal action may be brought to recover on this insurance within 60 days after written proof of loss has been given as required by the policy. No such action may be brought after 6 years from the time written proof of loss is required to be given.

SOUTH DAKOTA RESIDENTS:

The definition of Pre-existing Condition is amended to read:

“Pre-existing Condition” for the purposes of the policy shall mean (a) A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve months immediately preceding the effective date of coverage; (b) A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage; or (c) A pregnancy existing on the effective date of coverage.

The exclusion related to drug use and intoxication is amended to read:

8. Being under the influence of alcohol or having taken drugs or narcotics unless prescribed by a legally qualified Physician or surgeon to the extent that a person was committing a felony at the time of the loss;

The exclusions related to alcohol and drug use are amended to read:

25. Treatment in connection with alcoholism and drug addiction, or use of any drug or narcotic agent to the extent that a person was committing a felony at the time of the loss;
26. Injury sustained while under the influence of or Disablement due to wholly or partly to the effects of intoxicating liquor or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician for a condition which is covered hereunder to the extent that a person was committing a felony at the time of the loss;

TENNESSEE RESIDENTS:

Definitions:

The definition of Accident is replaced with the following:

“Accident” or “Accidental” shall mean an event, independent of illness, which is the direct cause of bodily injury to You.

The definition of “Dependent” is replaced with the following:

“Dependent” shall mean the spouse who is legally married to You; Your unmarried Child until his/her 19th birthday; or Your unmarried Child who is over 18 years old but not older than 23 years old and is enrolled as a full-time student at an accredited school or college and is not employed on a full-time basis and is dependent on You for his/her support and maintenance. The age limits that apply to Your Dependent Child(ren) will not apply to any insured Child who remains dependent on You for support and maintenance because he or she becomes incapable of working due to a physical handicap or retardation which occurs: before reaching the age limit; and while insured

under the policy or any prior plan, provided such Child was insured on the date of termination of the prior plan.

The definition of “Injury” is replaced with the following:

“Injury” wherever used in the policy shall mean bodily Injury caused solely and directly by means occurring while the policy is in force and resulting directly and independently of all other causes in Disablement covered by the policy.

The first part of the definition of “Medically Necessary” is revised to read as follows: **“Medically Necessary”** or **“Medical Necessity”** shall mean services and supplies received by You while insured that are determined by the Assistance Company to be:

The definition of “Physician” is replaced with the following: **“Physician”** as used in the policy shall mean a doctor of medicine or a doctor of osteopathy licensed to render medical services or perform Surgery in accordance with the laws of the jurisdiction where such professional services are performed.

The definition of “Reasonable and Customary” is replaced in its entirety with the following: **“Reasonable and Customary”** shall mean the maximum amount that the Company determines is Reasonable and Customary for Covered Expenses You receive, up to but not to exceed charges actually billed. The Company’s determination considers: 1) amounts charged by other Service Providers for the same or similar service in the locality were received, considering the nature and severity of the bodily Injury or Illness in connection with which such services and supplies are received; 2) any unusual medical circumstances requiring additional time, skill or experience; and 3) other factors the Company determines are relevant, including but not limited to, a resource based relative value scale.

The following exclusions are revised as follows:

Exclusion 2. is replaced with the following:

Suicide or attempt thereof by You while sane or intentional self destruction or any attempt thereof by You while insane;

Exclusion 4. the sections "Any consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to, or arising in connection with" and "Any consequence happening or arising during the existence of abnormal conditions (whether physical or otherwise), whether directly or indirectly, proximately or remotely occasioned by, or contributed to by, traceable to, or arising in connection with, any of the said Occurrences shall be deemed to be consequences for which the Company shall not be liable under the policy except to the extent that You shall prove that such consequence happened independently of the existence of such abnormal conditions" are deleted.

Exclusion 4.b. is replaced with the following:

4.b) Your participation in riot, insurrection, rebellion or revolution.

Exclusion 21. related to cosmetic or plastic surgery is replaced with the following:

21. Cosmetic or plastic surgery, except as the result of a covered Accident; for the purposes of the policy, treatment of a deviated nasal septum as the result of a broken nose incurred due to a covered injury shall not be considered a cosmetic condition;

Exclusion 26. related to injury sustained while under the influence of alcohol or drugs is replaced with the following:

26. Injury sustained by You or a covered person while under the influence of or Disablement due to wholly or partly to the effects of intoxicating liquor or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician for a condition which is covered hereunder but not for the Treatment of drug addiction;

Exclusion 28. related to self-inflicted injury or illness is amended to read:

28. Expenses as a result of or in connection with intentionally self-inflicted Injury or Accident;

The **GENERAL PROVISIONS** section is amended by the addition of the following provisions:

Proof of Loss: Written Proof of Loss must be furnished to the Company at its said office in case of claim for Loss for which this policy provides any periodic payment contingent upon continuing Loss within 90 days after the termination of the period for which the Company is liable and in case of claim for any other Loss within ninety days after the date of such Loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claims if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

Physical Examination and Autopsy: The Company at its own expenses shall have the right to examine the person of any individual whose Injury or Illness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

The Excess Benefits provision is deleted in its entirety and replaced with the following:

Benefits: All coverages, shall be payable as primary coverage.

The Subrogation provision is replaced with the following:

SUBROGATION: In the event of payment to any person under the coverage required by this part, and subject to the terms and conditions of such coverage, the Company making such payment shall, to the extent thereof, be subrogated to all of the rights of the person to whom such payment has been made, and shall be entitled to the proceeds of any settlement or judgment resulting from the

exercise of any rights of recovery of such person against any person or organization legally responsible for the Injury or damage for which such payment is made, including the proceeds recoverable from the assets of an insolvent insurer. Payment by the Company under the coverage required by this part shall not constitute a satisfaction of the liability of the party or parties responsible for such injury or damage. Such recovery by the Company shall allow You to recover legal fees You incurred in a third party situation.

TEXAS RESIDENTS:

The **GENERAL PROVISIONS** section is amended by the addition of the following provisions:

The Claimant must send the Company, or its designated representative, proof of loss within ninety-one (91) days after a covered loss occurs or as soon as reasonably possible.

The Company shall, not later than the 15th day after receipt of such notice of a claim: a) acknowledge receipt of the claim; b) commence any investigation of the claim; and c) request from the Claimant all items, statements, and forms that the Company reasonably believes, at that time, will be required from the claimant. Additional requests may be made if during the investigation of the claim such additional requests are necessary. If the acknowledgement of the claim is not made in writing, the Company shall make a record of the date, means, and content of the acknowledgement.

The Company shall notify a claimant in writing of the acceptance or rejection of the claim not later than the 15th business day after the date the Company receives all items, statements, and forms required by the Company, in order to secure final proof of loss. If the company rejects the claim, the Company will inform the Claimant of the reasons for the rejection. If the Company is unable to accept or reject the claim within 15 business days after the date the Company receives all items, statements, and forms required by the Company, the Company shall notify the claimant within such 15 business day period. The notice provided must give the reasons that the Company

needs additional time. Not later than the 45th day after the date the Company notifies a Claimant of the need for additional time to investigate a claim, the Company shall accept or reject the claim.

Except as otherwise provided, if the Company delays payment of a claim following its receipt of all items, statements, and forms reasonably requested and required for more than 60 days, the Company shall pay, in addition to the amount of the claim, 18 percent per annum of the amount of such claim as damages, together with reasonable attorney fees. If suit is filed, such attorney fees shall be taxed as part of the costs in the case.

“Business Day” means a day other than a Saturday, Sunday, or holiday recognized by Texas. If the Company notifies a claimant that the Company will pay a claim or part of a claim, the Company shall pay the claim not later than the fifth business day after the notice has been made. If the claimant conditions payment of the claim or part of the claim on the performance of an act, the Company shall pay the claim not later than the fifth business day after the date the act is performed.

The provision entitled “**When Your Coverage Ends**” is amended by the addition of the following:

Coverage will not end solely because a person becomes an elected official in Texas.

The following Legal Actions provision is added:

LEGAL ACTIONS: No action in any form can be brought after two years and one day after the Loss.

UTAH RESIDENTS:

The **GENERAL PROVISIONS** section is amended by the addition of the following provisions:

Claims must be submitted within 90 days from the date of loss. Failure to file within the 90 days will not invalidate a claim if You show that it was not possible to file within such time limit.

Once a claim has been adjusted for insurance benefits

and the proper proof of loss has been filed for such insurance benefits, claim payment will be made within 30 days of such date.

VIRGINIA RESIDENTS:

The following revisions apply to the **DEFINITIONS** section:

The definition of Dependent is deleted in its entirety and replaced with the following:

“**Dependent**” shall mean the spouse who is legally married to You; Your unmarried Child from birth until his/her 19th birthday; or Your unmarried Child who is:

1. over 18 years old but not older than, 25 years old and is enrolled as a full-time student at an accredited school or college and is not employed on a full-time basis and is dependent on You for his/her support and maintenance, or;
2. Who is over 18 years old but not older than 25 years old and is a full time student and is unable to continue as a full-time student because of a medical condition.

The age limits that apply to Your Dependent Child(ren) will not apply to any insured Child who remains dependent on You for support and maintenance because he or she becomes incapable of working due to a physical handicap or retardation which occurs: before reaching the age limit; and while insured under the policy or any prior plan, provided such Child was insured on the date of termination of the prior plan.

The Definition of Pre-existing condition is deleted in its entirety and replaced with the following:

“**Pre-existing Condition**” for the purposes of the policy shall mean a condition that would have caused a person to seek medical advice, diagnosis, care or Treatment during the 12 months prior to the Effective Date of coverage under the policy.

The definition of Service Provider is deleted in its entirety and replaced with the following:

“**Service Provider**” shall mean 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, optometrist, optician, professional counselor, psychologist, clinical social worker, podiatrist, physical therapist, chiropodist, clinical nurse specialist who renders mental health services, audiologist, speech pathologist, certified nurse midwife, marriage and family therapist or licensed acupuncturist, Registered Nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility that the Company approves.

The following revisions apply to the **LIMITATIONS AND EXCLUSIONS** section:

The Pre-Existing Condition exclusion is revised as follows:

1. Pre-existing Conditions for the continuous 12 month period after the policy effective date during which You receive no medical advice or treatment in connection with the Pre-existing condition, or the earlier of the policy expiration date or the end of the two year period commencing on the effective date of the persons coverage. This exclusion does not apply to Emergency Evacuation/Repatriation;

Exclusions #4c is deleted in its entirety as losses due to Acts of Terrorism are not excluded for Virginia residents.

The **Emergency Medical Evacuation/Repatriation, Additional Benefits** section is deleted in its entirety.

The following revisions apply to the **GENERAL PROVISIONS** section:

The **SUBROGATION PROVISION** is deleted in its entirety.

The **EXCESS BENEFITS PROVISION** is deleted in its entirety.

The **GENERAL PROVISIONS** section is amended by the addition of the following provisions:

1. Written notice of claim is to be provided to the Company within 20 days of the loss or medical expense incurred. Failure to give notice within 20 days shall not invalidate or reduce any claim if it can be shown that notice was given as soon as reasonably possible.
2. The Company will furnish forms for filing a proof of loss. These forms will be provided to You within 15 days of notice of loss. If such forms are not furnished by the Company to You within such 15 days, the person making the claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy the filing of proof of loss covering the occurrence.
3. Proof of loss shall be provided to the Company within 90 days after the date of Loss or incurred medical expense. Failure to furnish such proof of Loss within 90 days shall not invalidate or reduce any claim if it was not reasonably possible to furnish the proof of loss within that time frame and proof of loss is furnished as soon as reasonably possible. In no event, except in the absence of the legal capacity of the claimant, shall proof of loss be furnished later than 1 year from the time proof is otherwise required.
4. Benefits payable under the policy shall be paid within 60 days after receipt of proof of loss.
5. Benefits for the loss of life of the insured person shall be payable to the beneficiary designated by the person insured.

WASHINGTON RESIDENTS:

The definition of Pre-Existing Condition has been amended to the following:

“Pre-existing Condition” for the purposes of the policy shall mean 1) a condition that would have caused a person to seek medical advice, diagnosis, care or treatment 36 months prior to the Effective Date of coverage under the policy; 2) a condition for which

medical advice, diagnosis, care or treatment was recommended or received during the 36 months prior to the Effective Date of coverage under the policy.

Exclusion #4 is amended to read as follows:

4. War, whether declared or not declared;

All references to Terrorism is deleted in its entirety.

WISCONSIN RESIDENTS:

With regard to the provision entitled “Subrogation”, subrogation will not take place until the person has been made whole for any claim payable under the policy.

WYOMING