

Description of Coverage

PLEASE READ THIS DOCUMENT CAREFULLY!



Marketed by



Schedule of Benefits

<u>Benefits (Per Person)</u>	<u>Maximum Limit</u>
Medical Expense (Primary).....	\$5,000
Emergency Medical Evacuation.....	\$200,000
Accidental Death & Dismemberment (Principal Sum)....	\$5,000
The following non-insurance services are provided by the Worldwide Assistance Center through AIG Assist:	
24-hour Medical Assistance.....	Included

Benefits are valid only if premium has been paid.

A Blanket Travel Accident Insurance Policy

This document describes the benefits and basic provisions of the Policy. Read this document with care. The Policy is the only contract under which benefits are paid.

Definitions

“Common Carrier” means any conveyance operated under a license for the transportation of passengers for hire.

“Complication of Pregnancy” means a condition whose diagnosis is distinct from pregnancy but adversely affected or caused by pregnancy. It does not include any condition associated with the management of a difficult pregnancy not consisting of a classifiable distinct Complication of Pregnancy.

“Contracted Departure Date” means the date on which the Insured is originally scheduled to leave on his/her Trip.

“Contracted Return Date” means the date on which the

Insured is scheduled to return to the point where the Trip started, or to a different specified Return Destination.

“Destination” means the place where the Insured expects to travel on his/her Trip.

“Experimental or Investigative” means treatment, a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice, and any of those items requiring federal or other governmental agency approval not received at the time services are rendered.

“Hospital” means a place that: (a) holds a valid license; (b) is run mainly for the care and treatment of sick or injured persons as inpatients; (c) has a staff of one or more Physicians available at all times; (d) provides 24-hour nursing service and has at least one registered nurse on duty at all times; (e) has organized diagnostic and surgical facilities, either on the premises or on a contract basis with another Hospital; and (f) is not mainly a clinic, or facility for nursing, rest or convalescence, or a place for the aged.

“Injury” means a bodily injury caused by an accident occurring while the Policy is in force as to the Insured whose injury is the basis of a claim, and resulting directly and independently of all other causes of loss covered by the Policy. The injury must be verified by a Physician.

“Insured” means the person named on the individual Enrollment Form.

“Insurer” means National Union Fire Insurance Company of Pittsburgh, PA.

“Medically Necessary” means that a treatment, service, or supply: (a) is essential for diagnosis, treatment, or care of the Injury or Sickness for which it is prescribed or performed; (b) meets generally accepted standards of medical practice; (c) is ordered by a Physician and performed under his or her care, supervision, or order; and (d) is not primarily for the convenience of the Insured, Physician, other providers, or any other person.

“Physician” means a licensed practitioner of the healing arts including accredited Christian Science Practitioners, acting within the scope of his/her license. The treating Physician may not be the Insured, Immediate Family Member, or a Traveling Companion.

“Pre-Existing Medical Condition Exclusion” (Applicable to all coverages except Emergency Medical Transportation):

The Insurer will not pay for loss or expense incurred as the result of Injury, Sickness or other condition of the Insured, which, within the 60 day period before the Insured’s coverage began: (a) first manifested itself, worsened, became acute, or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment; (b) required taking prescribed drugs or medicine, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or (c) required treatment by a Physician or treatment had been recommended by a Physician.

“Reasonable and Customary Charges” means an expense which: (a) is charged for treatment, supplies, or medical services Medically Necessary to treat the Insured’s condition; (b) does not exceed the usual level of charges for similar treatment, supplies or medical services in the locality where the expense is incurred; and (c) does not include charges that would not have been made if no insurance existed. In no event will the Reasonable and Customary Charges exceed the actual amount charged.

“Return Destination” means the place to which the Insured expects to return from his/her Trip.

“Sickness” means an illness or disease diagnosed or treated by a Physician.

“Trip” means a period of round-Trip travel away from home to a Destination outside the Insured’s city of residence; the purpose of the Trip is business or pleasure and is not to obtain health care or treatment of any kind; the Trip has defined departure and return dates specified when the Insured applies; the Trip does not exceed 180 days; the Insured’s Destination is not to another home.

Individual Eligibility

Effective and Termination Dates

Eligibility: Persons eligible for insurance under the Policy are any traveler who purchases insurance through or from a properly licensed agent/agency located in the U.S. or Canada who enrolls for coverage and pays the premium, providing they have not already departed on their Trip.

Effective Date: After premium is paid and the Roster is completed and signed coverages will begin on the later of: (a) the date and time the Insured starts his/her Trip, or (b) the scheduled Contracted Departure Date shown on the Roster.

Termination Date: All coverage ends on the earlier of: (a) the date the Trip is completed; (b) the scheduled Contracted Return Date; (c) the Insured’s arrival at the Return Destination on a round Trip, or the Destination on a one-way Trip; or (d) the cancellation date of the Trip covered by the Policy.

Extension of Coverage: All coverage under the Policy will be extended, if: (a) the Insured’s entire Trip is covered by the Policy; and (b) the Insured’s return is delayed by unforeseeable circumstances beyond his/her control. If coverage is extended for the above reasons, coverage will end on the earlier of: (a) the date the Insured reaches his/her Return Destination; or (b) seven days after the date the Trip was scheduled to be completed.

General Exclusions

These exclusions apply to all benefits. In addition to any exclusions which apply to a particular benefit (called “Additional Exclusions”), the Policy does not cover loss caused by or as a result of:

- (a) intentionally self-inflicted Injury or any attempt at an intentionally self-inflicted, suicide, or attempted suicide by the Insured (while sane, in Colorado and Missouri);
- (b) pregnancy or childbirth, or elective abortion, other than the Complications of Pregnancy;
- (c) participation in professional, semi-professional,

organized or interscholastic team sports athletic events, motor sport, or motor racing, including training or practice for the same;

(d) mountain climbing;

(e) war or act of war, whether declared or not, civil disturbance, riot, or insurrection;

(f) military duty or service;

(g) operating or learning to operate any aircraft, as student, pilot, or crew;

(h) air travel on any air-supported device, other than a regularly scheduled airline or air charter company;

(i) any unlawful acts, committed by the Insured, whether insured or not;

(j) mental, psychological or nervous disorders including, but not limited to, anxiety, depression, neurosis or psychosis (not applicable to residents of Florida);

(k) alcohol or substance abuse or treatment for same;

(l) medical treatment during or arising from a Trip undertaken for the purpose or intent of securing medical treatment or traveling expressly for the purpose of obtaining medical treatment;

(m) elective or non-emergency treatment or surgery, except for any necessary treatment or surgery due to covered Injury or Sickness;

(n) Experimental or Investigative treatment or procedures; or

(o) an Injury or Sickness which occurs at a time when this coverage is not in effect.

Medical Expense Benefit

The Insurer will pay this Primary benefit up to the Maximum Limit shown on the Schedule of Benefits. The Insurer will pay for Reasonable and Customary Charges for Medically Necessary expenses incurred by the Insured within one year from the date of Injury or Sickness, provided initial treatment was received during the Trip. The Injury must occur or Sickness must begin while the Insured is covered by the Policy.

Covered Expenses: The Insurer will pay for: (a) medical and surgical services of a Physician; (b) professional nursing care; (c) Hospital charges; (d) X-rays; (e) ambulance services; (f) prosthetic devices; and (g) medication or drugs administered by a Physician. Physical therapy will be covered up to 90 days after the Insured reaches his/her Return Destination. The Insurer will pay emergency dental treatment only during a Trip. Dental coverage does not apply if treatment or expenses are

incurred after the Insured has reached his/her Return Destination, regardless of the reason. The treatment must be given by a Physician or dentist. Benefits payable will not exceed Reasonable and Customary Charges for similar services in the geographic area in which the services were rendered.

Additional Exclusions: In addition to the General Exclusions, coverage is not provided for: (a) routine physical examinations; (b) mental health care; (c) replacement of hearing aids, eye glasses, contact lenses, sunglasses, and artificial teeth; (d) routine dental care; (e) any service provided by the Insured, an Immediate Family Member, or Traveling Companion; or (f) amounts paid or awarded under any workers' compensation disability benefit or similar law.

Requirements in the Event of a Loss: The Insured must provide the Insurer with: (a) all medical bills and reports for medical expenses claimed; and (b) a signed patient authorization to release medical information to the Insurer.

Emergency Medical Evacuation

The Insurer will pay this benefit up to the Maximum Limit shown on the Schedule of Benefits. The Worldwide Assistance Center will arrange for emergency medical transportation services required by the Insured as the result of any Injury or emergency Sickness during a Trip.

Covered Expenses: The Insurer will pay: (a) Reasonable and necessary charges required for evacuation to the nearest adequate medical facility or home if medically required. This service will be arranged only if the Insured's Physician determines that adequate medical treatment is not locally available; (b) Reasonable and necessary charges for services for transportation of the Insured's remains to his/her place of residence if he/she dies during a Trip.

Services must be provided by a provider designated by the Worldwide Assistance Center. Timely notification by the Insured to the Worldwide Assistance Center is required, with regard to emergency evacuation.

Requirements in the Event of a Loss: The Insured must call the Worldwide Assistance Center at 1.877.653.2513 or 1.715.342.3541 (collect) prior to arranging emergency medical transportation. Failure to do so may affect coverage.

Accidental Death and Dismemberment

The Insurer will pay this benefit up to the Maximum Limit shown on the Schedule of Benefits if: (a) the Insured is injured in an accident which happens while he/she is on a Trip and covered under the Policy; and (b) he/she suffers one of the losses listed below, within 365 days of the accident. The Principal Sum is shown on the Schedule of Benefits. The Insurer will not pay more than the Principal Sum for all losses due to the same accident.

Loss	Percentage of Principal Sum Payable
Life.....	100%
Both hands or feet, or sight of both eye.....	100%
One hand and one foot	100%
One hand or one foot and sight of one eye.....	100%
One hand	50%
One foot	50%
Sight of one eye.....	50%

In no event will the Insurer pay more than the Maximum Limit shown on the Schedule of Benefits for all losses due to the same accident. If the Insured suffers more than one loss from an accident, the Insurer will pay only for the loss with the larger benefit. Loss of a hand or foot means complete severance at or above the wrist or ankle joint. The Insurer will not pay more than 100% of the Principal Sum for all losses due to the same accident. Loss of sight of an eye means complete and irrecoverable loss of sight. Additional Exclusion: In addition to the General Exclusions, the Insurer will not pay for loss caused by or resulting from Sickness or disease of any kind.

Payment of Claims

Claim Procedures: Notice of Claim: The Insured must call as soon as reasonably possible, and be prepared to provide: (a) the Policy's benefit provision(s) that are the basis of the claim (i.e. Medical Expenses), (b) the name of the company that arranged the Trip (i.e., tour operator, cruise line, or charter operator), the (c) the Trip dates. A claim form will be completed for the Insured to review and sign along with a list of items the Insured must attach to substantiate the loss. The completed form and any attachments should be returned to: Claims Department, P.O. Box 47, Stevens Point, Wisconsin 54481 (telephone 1.715.342.3541 or 1.877.653.2513). All California claims will be administered by Mercury Claims Administrator Services, LLC.

Claim Procedures: Proof of Loss: The claim forms must be sent back to the Claims Department no more than 90

days after a covered loss occurs or ends, or as soon as reasonably possible thereafter. All claims under the Policy must be submitted to the Claims Department no later than one year after the date of loss or insured occurrence or as soon as reasonably possible. If the Claims Department has not provided claim forms within 15 days after the notice of claim, other proofs of loss should be sent to the Claims Department by the date claim forms would be due. The proof of loss should include written proof of the occurrence, type and amount of loss, the Insured's name, the participating organization name, and the policy number.

Payment of Claims: When Paid: Claims will be paid as soon as the Claim Department receives complete proof of loss and verification of age.

Payment of Claims: To Whom Paid: Benefits paid on account of an Insured's death will be paid to the beneficiary he/she has chosen. This choice must be in writing and filed with the Insurer, or filed with the Insurer or Insurer's administrator if Insurer has agreed in advance. If the Insured has not chosen a beneficiary, or if there is no beneficiary alive when he/she dies, Insurer will pay this benefit:

- (a) To his/her spouse, if living.
- (b) If there is none, in equal shares to his/her living children.
- (c) If there are none, in equal shares to his/her living parents.
- (d) If there are none, in equal shares to his/her living brothers and sisters.
- (e) If there are none, to his/her estate.

If a benefit is payable to a minor or other person who is incapable of giving a valid release, the Insurer may pay up to \$1,000 to a relative by blood or connection by marriage who has assumed care or custody of the minor or responsibility for the incompetent person's affairs. Any payment Insurer makes in good faith fully discharges Insurer to the extent of that payment.

All other benefits will be payable to the Insured. However, if he/she has assigned his/her benefits, Insurer will honor the assignment, if Insurer has a signed copy of the assignment. A payment made pursuant to such an assignment shall discharge Insurer from further liability under the Policy to the extent of such payment. Under no circumstances shall Insurer be responsible for the validity or sufficiency of any such assignment.

General Provisions

Acts of Agents: No agent or any person or entity has authority to accept service of the required proof of loss or demand arbitration on the Insurer's behalf nor to alter, modify, or waive any of the provisions of the Policy.

Autopsy: The Insurer at its own expense, may require an autopsy where permitted by law.

Concealment or Fraud: The Insurer does not provide coverage for the Insured if the Insured has intentionally concealed or misrepresented any material fact or circumstance relating to the Policy or claim.

Insurer's Recovery Rights: In the event of a payment under the Policy, the Insurer is entitled to all rights of recovery that the Insured, or the person to whom payment was made, has against another. The Insured must sign and deliver to the Insurer any legal papers relating to that recovery, do whatever is necessary to help the Insurer exercise those rights, and do nothing after the loss to harm the Insurer's rights. When an Insured has been paid benefits under the Policy but also recovers from another policy, the amount recovered from the other policy shall be held in trust for the Insurer by the Insured and reimbursed to the Insurer the extent of the Insurer's payment. This provision does not apply in North Carolina or where prohibited by law.

Legal Actions: No one may sue for benefits less than 60 days after due proof of loss is submitted, nor more than 3 years (or the minimum period of time permitted by state law, if greater) after the date claim forms are due.

Payment of Premium: Coverage is not effective unless all premium due has been paid.

Termination of the Policy: Termination of the Policy will not affect a claim for loss which occurs while the Policy is in force.

Transfer of Coverage: Coverage under the Policy cannot be transferred by the Insured to anyone else.

State Notifications

Notice to California residents: The plan contains disability insurance benefits or health insurance benefits, or both, that only apply during your covered Trip. You may have coverage from other sources that already provides you with these benefits. You should review your existing policies. If you have any questions about your current coverage, call your insurer or health plan.

Notice to Florida residents: The benefits of the Policy providing your coverage are governed primarily by the law of a state other than Florida.

The definition of "**Hospital**" applicable to residents of Florida is as follows: Hospital means a facility that: (a) is operated according to law for the care and treatment of injured people; (b) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis or is accredited by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities; (c) has 24 hour nursing service by registered nurses (R.N.'s); and (d) is supervised by one or more Physicians. A Hospital does not include: (a) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; (b) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes; or (c) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

The Legal Actions provision applicable to residents of Florida is as follows: No action at law or in equity may be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action may be brought after the expiration of 5 years after the time written proof of loss is required to be furnished.

For inquiries, information about coverage or for assistance in resolving complaints call: 1.877.653.2513.

Notice to North Carolina residents: This Description of Insurance provides all of the applicable benefits mandated by the North Carolina Insurance code, but is issued under a master policy located in another state and may be governed by that state's laws.

Notice to Texas residents: The Policy may provide a duplication of coverage already provided by the Insured's personal auto insurance, homeowner's, personal liability policy, or other source of coverage.

Medevac200 is Underwritten By

Underwritten by National Union Fire Insurance Company of Pittsburgh, PA, NAIC No. 19445, a member of the AIG Companies® with their principal place of business at 70 Pine Street, New York, NY 10270 and currently authorized to transact business in all states and the District of Columbia.

This is only a brief description of the insurance coverage(s) available under policy series T30253NUFIC. The Policy contains reductions, limitations, exclusions, and termination provisions. Full details of the coverage are contained in the Policy. If there are any conflicts between this document and the Policy, the Policy shall govern.

MAXIMUM LIMIT OF LIABILITY: All limits are applied per Trip. The Insurer's maximum limit of liability resulting from the same occurrence will be \$10,000,000 under the Policy Series T30253NUFIC underwritten by National Union Fire Insurance Company of Pittsburgh, PA,. If loss for all Insureds from such an occurrence exceeds \$10,000,000 the Insurer will pay each Insured that proportion of the Benefits stated which \$10,000,000 bears to the total loss of all persons the Insurer insures under all travel and flight insurance in force, under the TGP Policies. The Insurer will pay no more than \$250,000 per occurrence, under the TGP Policies, to or on account of any person insured under the TGP Policies.

WORLDWIDE ASSISTANCE CENTER

The following benefits are service benefits only, not insurance benefits. Any costs incurred for these services will be the responsibility of the Insured, unless specifically covered elsewhere under the Policy.

24-HOUR MEDICAL ASSISTANCE

24-Hour Medical Monitoring: Physicians monitor your condition by maintaining close contact with the attending Physicians, your family Physician and Immediate Family Members.

Medical Evacuation: Arrangements for any and all means necessary to transport you back home when medically necessary.

Emergency Medical Payments: If a Hospital demands cash deposit or settlement prior to leaving, arrangements will be made for the advancement of funds to cover on-site medical expenses.

Prescription Assistance: Replacement of lost or stolen medication, through a local pharmacy or special courier.

Family Visit: If you are hospitalized for more than 7 days, arrangements will be made for transportation of an Immediate Family Member or close friend to visit you.

Transportation of Mortal Remains: In the event of death while traveling, arrangements and payment for the return of remains to the place of burial.

Preferred Provider Network - Make sure you call 1.877.653.2513 or 1.715.342.3541 (collect) before you seek medical care while traveling. Where available, we can arrange direct payment to a member of our preferred medical network, saving you the time and paperwork associated with reimbursement of medical expenses. Our assistance coordinators also can help you locate the nearest and most appropriate medical provider, monitor your care, and provide updates to your family and/or employer.

Trade Sanction Notice

Any payments under this Policy will only be made in full compliance with all United States of America economic or trade sanction laws or regulations, including, but not limited to, sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"). Therefore, any expenses incurred or claims made involving travel that is in violation of such sanctions, laws and regulations will not be covered under this Policy. For more information, you may consult the OFAC internet website at www.treas.gov/offices/enforcement/ofac/.

----- cut out and keep this card with you -----

Worldwide Assistance Center 24 Hour Telephone Numbers

Continental USA.....1.877.653.2513

International.....1.715.342.3541 (call collect)

Use the appropriate country codes when calling.

MedEvac200™

Product Code: TIS401