VenbrookEssential

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

The Company hereby insures all persons whose application has been accepted by Our administrator on behalf of the Company, subject to all the exclusions, limitations and provisions set forth in this Policy. Coverage is afforded only with respect to the Covered Person, the coverage, the amounts, and the limits specified in the Certificate issued to the Covered Person, for which premium has been paid.

SCHEDULE OF BENEFITS

POLICY MAXIMUM BENEFITS

Policy Maximum per Policy Period	**$25,000**	**$50,000**	**$100,000**	**$150,000**
Age Eligibility	Ages 0 – 89	Ages 0 – 79	Ages 0 – 79	Ages 0 – 69
Deductible per Policy Period	Ages 0 – 69: $0 Ages 70-89: $100, $200	Ages 0 – 69: $0 Ages 70-79: $100, $200	Ages 0 – 69: $0 Ages 70-79: $100, $200	Ages 0 – 69: $0
Co-Insurance per Policy Period	None	None	None	None
Benefit Period	180 days	180 days	180 days	180 days
Medical – Inpatient Services				
Covered Treatment of Service	**Maximum Benefit**	**Maximum Benefit**	**Maximum Benefit**	**Maximum Benefit**
Hospital Room and Board Including Ancillary Hospital Services	Up to $1,500 per day, 30 day maximum per annual period	Up to $2,250 per day, 30 day maximum per injury/illness	Up to $2,500 per day, 30 day maximum per injury/illness	Up to $3,250 per day, 30 day maximum per injury/illness
Intensive Care Unit	Up to $2,250 per day, 10 day maximum per annual period	Up to $2,750 per day, 8 day maximum per injury/illness	Up to $3,000 per day, 8 day maximum per injury/illness	Up to $4,750 per day, 8 day maximum per injury/illness
Inpatient Surgery	Up to $4,000 per surgical session	Up to $6,000 per surgical session	Up to $7,250 per surgical session	Up to $8,000 per surgical session
Anesthesia	Up to $900 per surgical session	Up to $1,250 per surgical session	Up to $1,500 per surgical session	Up to $2,000 per surgical session
Assistant Surgeon	Up to $900 per surgical session	Up to $1,250 per surgical session	Up to $1,500 per surgical session	Up to $2,000 per surgical session
Physician's Non-Surgical Visits	Up to $60 per visit, 30 visits per Policy Period	Up to $80 per visit, 30 visits per Policy Period	Up to $125 per visit, 30 visits per Policy Period	Up to $150 per visit, 30 visits per Policy Period

Consult Physician, when Requested by Attending Physician	Up to $500 per Policy Period	Up to $600 per Policy Period	Up to $650 per Policy Period	Up to $750 per Policy Period
Private Duty Nurse	Up to $500 per Policy Period	Up to $600 per Policy Period	Up to $650 per Policy Period	Up to $750 per Policy Period
Pre-Admission Tests within 7 days Before Hospital Admission	Up to $1,250 per Policy Period	Up to $1,375 per Policy Period	Up to $1,500 per Policy Period	Up to $1,750 per Policy Period
Medical – Outpatient Services				
Covered Treatment of Service	**Maximum Benefit**	**Maximum Benefit**	**Maximum Benefit**	**Maximum Benefit**
Physician Visit	Up to $60 per visit, 1 per day, 30 visits maximum	Up to $80 per visit, 1 per day, 10 visits maximum	Up to $110 per visit, 1 per day, 10 visits maximum	Up to $150 per visit, 1 per day, 10 visits maximum
Virtual Visit / Telemedicine	Included	Included	Included	Included
Urgent Care / Walk-in Clinic	Up to $60 per visit, 1 per day, 30 visits maximum	Up to $80 per visit, 1 per day, 10 visits maximum	Up to $110 per visit, 1 per day, 10 visits maximum	Up to $150 per visit, 1 per day, 10 visits maximum
Emergency Room, All Expenses In curred	$400 per injury/illness Extra $250 deductible for illness visit that does not result in hospital admission.	$600 per injury/illness Extra $250 deductible for illness visit that does not result in hospital admission.	$750 per injury/illness Extra $250 deductible for illness visit that does not result in hospital admission.	$750 per injury/illness Extra $250 deductible for illness visit that does not result in hospital admission.
Prescription Drugs	Up to $250 per annual Policy Period, maximum of 90 days per prescription	Up to $400 per injury/illness, maximum of 60 days per prescription	Up to $400 per injury/illness, maximum of 60 days per prescription	Up to $500 per injury/illness, maximum of 60 days per prescription
Diagnostic X-rays and Lab Services	Up to $500; Up to $750 for one CAT scan, PET Scan or MRI, per injury/illness	Up to $750; Up to $900 for one CAT scan, PET Scan or MRI, per injury/illness	Up to $900; Up to $1,100 for one CAT scan, PET Scan or MRI, per injury/illness	Up to $1,100; Up to $1,300 for one CAT scan, PET Scan or MRI, per injury/illness
Outpatient Surgery	Up to $4,000 per surgical session	Up to $6,000 per surgical session	Up to $7,250 per surgical session	Up to $8,000 per surgical session
Anesthesia	Up to $900 per surgical session	Up to $1,250 per surgical session	Up to $1,500 per surgical session	Up to $2,000 per surgical session
Assistant Surgeon	Up to $900 per surgical session	Up to $1,250 per surgical session	Up to $1,500 per surgical session	Up to $2,000 per surgical session
Outpatient Surgical Facility	Up to $1,250 per surgical session	Up to $1,300 per surgical session	Up to $1,400 per surgical session	Up to $1,500 per surgical session

Additional Medical Expense Benefits				
Covered Treatment of Service	**Maximum Benefit**	**Maximum Benefit**	**Maximum Benefit**	**Maximum Benefit**
Acute Onset of a Pre-Existing Condition				
Benefit Maximum	Up to Policy Maximum	Up to Policy Maximum	Up to Policy Maximum	Up to Policy Maximum
Medical Evacuation Sub-limit	$25,000	$25,000	$25,000	$25,000
Cardiovascular Event Sub-limit	$15,000	$25,000	$25,000	$25,000
Age Limit	Upon attaining age 70 Acute Onset of Pre-existing Condition benefits are not available.	Upon attaining age 70 Acute Onset of Pre-existing Condition benefits are not available.	Upon attaining age 70 Acute Onset of Pre-existing Condition benefits are not available.	Upon attaining age 70 Acute Onset of Pre-existing Condition benefits are not available.
COVID-19	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness
Well Doctor Visit	$250 for one visit. Minimum initial purchase of 30 days. Must occur within first 14 days from effective date.	$250 for one visit. Minimum initial purchase of 30 days. Must occur within first 14 days from effective date.	$250 for one visit. Minimum initial purchase of 30 days. Must occur within first 14 days from effective date.	$250 for one visit. Minimum initial purchase of 30 days. Must occur within first 14 days from effective date.
Dental Treatment for Injury to Sound Natural Teeth	Up to $650 per annual period	Up to $850 per annual period	Up to $850 per annual period	Up to $850 per annual period
Physical Therapy	Limited to $50 per visit, 1 per visit per day, 12 visits maximum Must be ordered in advance by physician.	Limited to $55 per visit, 1 per visit per day, 12 visits maximum Must be ordered in advance by physician.	Limited to $65 per visit, 1 per visit per day, 12 visits maximum Must be ordered in advance by physician.	Limited to $75 per visit, 1 per visit per day, 12 visits maximum Must be ordered in advance by physician.
Initial Orthopedic Prosthesis	Up to $1,250 per annual period for a standard basic hospital bed, standard basic wheelchair or the initial orthopedic prosthetic	Up to $1,500 per annual period for a standard basic hospital bed, standard basic wheelchair or the initial orthopedic prosthetic	Up to $1,750 per annual period for a standard basic hospital bed, standard basic wheelchair or the initial orthopedic prosthetic	Up to $2,000 per annual period for a standard basic hospital bed, standard basic wheelchair or the initial orthopedic prosthetic

Transportation Expenses				
Covered Treatment of Service	**Maximum Benefit**	**Maximum Benefit**	**Maximum Benefit**	**Maximum Benefit**
Local Ambulance	Up to $750 per injury/illness	Up to $750 per injury/illness	Up to $750 per injury/illness	Up to $750 per injury/illness
Emergency Medical Evacuation	Up to $100,000	Up to $100,000	Up to $100,000	Up to $100,000
Medically Necessary Repatriation	Up to $25,000	Up to $25,000	Up to $25,000	Up to $25,000
Emergency Reunion	$15,000, maximum of 15 days	$15,000, maximum of 15 days	$15,000, maximum of 15 days	$15,000, maximum of 15 days
Return of Minor Child(ren) or Traveling Companion	$2,250 per day for up to 10 days.	$2,250 per day for up to 10 days.	$2,250 per day for up to 10 days.	$2,250 per day for up to 10 days.
Return of Mortal Remains	$25,000	$25,000	$25,000	$25,000
Local Burial / Cremation	$5,000	$5,000	$5,000	$5,000
Additional Benefits & Services				
AD&D - Common Carrier	$25,000, maximum $125,000 per family or group	$25,000, maximum $125,000 per family or group	$25,000, maximum $125,000 per family or group	$25,000, maximum $125,000 per family or group
Incidental Trips Outside the United Sates	Included	Included	Included	Included
Home Country Coverage	Incidental: 14 days after 30 days continuous coverage	Incidental: 14 days after 30 days continuous coverage	Incidental: 14 days after 30 days continuous coverage	Incidental: 14 days after 30 days continuous coverage
****Travel Assistance**	Included	Included	Included	Included

** This is a non-insurance service and is not a part of the insurance underwritten by Crum & Forster, SPC.

GENERAL TERMS OF COVERAGE

ELIGIBILITY

This Policy provides coverage to non-US citizens who reside outside the USA and are traveling outside of Their Home Country to visit solely the United States, or to visit a combination of the United States and other countries worldwide. This Policy is not available to anyone age 90 or above.

This Policy is not available to any individual who has been residing within the United States for more than 365 days prior to their Effective Date.

We maintain Our right to investigate to verify that the eligibility requirements have been met. If and whenever We discover that the eligibility requirements have not been met, Our only obligation is refund of premium.

BENEFIT PERIOD

- While the Policy is in effect, we will pay eligible medical expenses for up to 180 days beginning on the first day of diagnosis or treatment of a covered Sickness or Injury; or
- Upon termination of the Policy, provided the Covered Person remains outside their Home Country and has not traveled back to their Home Country, we will continue to pay eligible medical expenses; up to 2 days following your Termination Date; or for up to 180 days beginning on the first day of diagnosis or treatment of a covered Sickness or Injury; or up to the maximum as stated under the Policy Medical Maximum; whichever occurs first; or
- Upon termination of the Policy, whereas the Covered Person returns to their Home Country the Benefit Period shall discontinue on the date of termination and the plan will no longer pay eligible medical expenses.

EFFECTIVE DATE

An eligible person will be insured on the latest of the following dates: 1. the Covered Person's departure from Their Home Country; or 2. the day after the Covered Person completed enrollment form and Their correct premium is received; or 3. the Effective Date requested and shown on the certificate.

TERMINATION DATE

The coverage provided with respect to the Covered Person shall terminate at 12:01 AM North American Central Time on the earliest of the following dates: 1. The day after the Termination Date shown on the insurance confirmation card, for which the premium is paid; or 2. The date the Covered Person returns to Their Home Country, except as provided under Return to Home Country Benefit, if eligible; or 3. Three hundred and sixty-four (364) days after the Covered Person's original effective date; or 4. The date the Covered Person becomes a United States citizen; or 5. The date the Covered Person is no longer eligible for this plan.

AUTOMATIC EXTENDED COVERAGE

Coverage will be automatically extended

1) If Your scheduled return is delayed due to unavoidable circumstances beyond Your control. This extension of coverage will end on the earlier of the date You reach Your originally scheduled date to return or 5 days after the Termination Date.
2) If You incur a covered Injury or Sickness on Your Trip and a treating Physician certifies that You are not Medically Fit to Travel to Your Home Country on Your Termination Date, the Medical Evacuation and Repatriation benefit will be automatically extended for 30 days or until You are Medically Fit to Travel and transported to Your Home Country or You reached the Maximum Benefit Amount shown in the Schedule of Benefits, whichever is sooner.
3) If You are Hospitalized due to a covered Injury or Sickness on Your Termination Date and a treating Physician certifies that You are not Medically Fit to Travel on Your Termination Date, this plan will be extended for an additional 30 days, or until You are released from the Hospital and Medically Fit to Travel, or You reached the Maximum Benefit Amount shown in the Schedule of Benefits, whichever is sooner.

OPTIONAL EXTENSION PROCEDURES

An extension notice will be sent to the Covered Person before the Policy Period ends and includes links to extend prior to the Termination Date. The Covered Person is subject to the following rules at extension: In order to extend, the Policy Period must be initially purchased for a minimum of 5 days. If available, an extension period can be purchased; 1.at the premium rate in force at the time of the extension; 2. for a minimum of 5 days; 3. for up to a maximum of 364 days, provided the Covered Person's Policy Period does not exceed 364 days in total. There are no

grace periods for extension. Once the Policy has lapsed, reapplication is required. Please note, upon application for a new Policy, the Pre-Existing Condition exclusion, deductible start over.

CANCELLATION AND REFUND PROCEDURE PROVISIONS

Full cancellation and refund will only be considered if We receive written request prior to or on the Effective Date of the coverage. If We receive a written request for cancellation and refund after the Effective Date of coverage, a partial cancellation and refund may be allowed. The following conditions apply: a) If any claims have been filed with Us, the premium is fully earned and is non-refundable; b) If no claims have been filed with the Company, then (i) a cancellation fee of US $25 will be charged; and (ii) only unused days premiums will be considered as refundable; and c) If after a refund is made, it is determined that a claim was presented to Us on a Covered Person's behalf, the Covered Person will be fully responsible for that claim in its entirety.

EXCESS INSURANCE

The coverage provided in this plan shall be in excess of all other valid and collectable insurance or indemnity and shall apply only when such other benefits are exhausted. In the event no other insurance exists this coverage becomes primary. The Insurance Company reserves the right to review and potentially subrogate with any undeclared coverage whether known or unknown to the Covered Person.

POLICY TERMS AND CONDITIONS

All benefits payable are subject to the Maximum Benefit Limits, and any applicable sub-limits, listed in the Schedule of Benefits.

MEDICAL EXPENSE BENEFIT

If a covered Sickness or Injury occurs during the Policy Period, and the Covered Person requires medical or surgical treatment, benefits are payable for the following covered expenses that are incurred during the Benefit Period. The first covered expenses must be incurred within 90 days after the date of the Covered Accident or Sickness. No benefits will be paid for any expenses incurred which are in excess of Usual and Customary Charges:

INPATIENT SERVICES

Inpatient services as specified in the Schedule of Benefits include, but are not limited to:

1. Hospital Room and Board Expenses: the average daily rate for a semi-private room when a Covered Person is Hospital Confined (In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge), and general nursing care and the following additional facilities; services and supplies as Medically Necessary and approved and covered by the Policy, meals and special diets (only for the patient). Use of operating room and related facilities, use of intensive care and related services. All charges in excess of the allowable semiprivate rate are the responsibility of the Covered Person.
2. Inpatient Ancillary Hospital Services - If medically necessary for the diagnosis and treatment of the Sickness or Injury for which a Covered Person is hospitalized, the following services are also covered: use of operation room and recovery room; all medicines listed in the U.S. Pharmacopoeia or National Formulary; Blood transfusions, blood plasma, blood plasma expanders, and all related testing, components, equipment and services; Surgical dressings; Laboratory testing; Durable Medical Equipment; Diagnostic x-ray examinations; Radiation therapy rendered by a radiologist for proven malignancy or neoplastic diseases; Respiratory therapy rendered by a Physician or registered respiratory therapist; chemotherapy rendered by a Physician or Nurse under the direction of a Physician; Physical and Occupational therapy (if covered) must be rendered by a Physician or registered physical or occupational therapist and relate specifically to the physician's written treatment plan. Therapy must: Produce significant improvement in the Insured's

condition in a reasonable and predictable period of time and be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed only by a registered physical or occupational therapist or be necessary to the establishment of an effective maintenance program. Maintenance itself is not covered. All Inpatient Ancillary benefits are paid in accordance with the current Schedule of Benefits.

3. Hospital Intensive Care Unit services will be provided based on the Allowable Charge for Medically Necessary Intensive Care Services.
4. Physician's Surgical Treatment.
5. Anesthesiologist Expenses for pre-operative screening and administration of anesthesia during a surgical procedure on an inpatient basis.
6. Assistant Physician's Surgeon (When Medically Necessary).
7. Physician's Non-Surgical Visits: Physician non-surgical treatment and examination expenses including the Physician's initial visit, each Medically Necessary follow-up visit and consultation visits when referred by the attending Physician.
8. Consulting Physician, when requested by attending Physician.
9. Private Duty Nurse.
10. Pre-Admission Test within 7 days of Admission.

OUTPATIENT SERVICES

Outpatient services as specified in the Schedule of Benefits include, but are not limited to:

1. Outpatient Physician Visits
2. Visits to Urgent Care and walk-in Facilities.
3. Hospital Emergency Room Visits. Emergency Room Visit for an Illness with no direct Hospital Admittance will be subject to an additional deductible as outlined in the schedule of benefits.
4. Prescription drugs and medications.
5. Diagnostic X-Rays and Lab Services: to include X-ray, laboratory and other diagnostic tests, biological anesthesia and oxygen services, radiation therapy, inhalation therapy, chemotherapy and administration of blood products. Chemotherapy and/or Radiation Therapy. Scans, PET scan or MRI.
6. Outpatient Surgical Facility.
7. Physician's Surgical Treatment.
8. Anesthesiologist Expenses for pre-operative screening and administration of anesthesia during a surgical procedure on an inpatient basis.
9. Assistant Physician Surgical Expenses.
10. Scans, PET scan or MRI.

ADDITIONAL MEDICAL EXPENSE BENEFITS

ACUTE ONSET OF PRE-EXISTING CONDITION for an Acute Onset of a Pre-Existing Condition up to the maximum as stated in the Schedule of Benefits provided the condition or event: 1. occurs spontaneously and without advance warning either in the form of Physician recommendations or symptoms, is of short duration, is rapidly progressive, and requires urgent and immediate medical care; 2. occurs a minimum of 48 hours after the Effective Date of the Policy; and 3. treatment is obtained within 24 hours of the sudden and unexpected outbreak or recurrence.

Any repeat/reoccurrence within the same Policy Period will no longer be considered Acute Onset of a Pre-Existing Condition and will not be eligible for additional coverage. This benefit covers only one (1) Acute Onset episode of a Pre-Existing Condition. Sudden and Acute Onset of a Pre-Existing Condition Coverage expires upon medical advice that the condition and onset is no longer acute, or the Covered Person is discharged from a medical facility.

Any covered Sickness or Injury that is payable under this benefit, will be subject any and all scheduled benefits, daily limits, sub-limits, terms and conditions as outlined under this policy.

WELL DOCTOR VISIT

Benefits will be payable for a Well Doctor Visit per person during the Policy Period. The Covered Person may use any Physician. To be covered:

1. the visit must occur within the first 21 days from the effective date of coverage: and
2. the Covered Person must purchase at least 30 days of coverage initially; and
3. the Physician must use specific ICD10 codes for the Well Visit which are the following three Diagnosis Codes only a) V70.0-Routine medical exam; b) Z00.00-Encounter for general adult medical examination without abnormal findings c) Z00.129-Encounter for routine child health examination without abnormal findings. Visits with ICD10 Codes not listed here are not considered Well Doctor Visits and are not covered.

DENTAL

Emergency dental treatment and restoration of sound natural teeth, including x-rays, required as a result of an Accident or to relieve pain.

EMERGENCY EYE EXAM

Emergency eye exam due to Accident that results in an Injury to Your eye(s). Your exam must occur within 48 hours of the Injury.

PHYSIOTHERAPY PHYSICAL MEDICINE/CHIROPRACTIC EXPENSES: Benefits provided on an Inpatient or outpatient basis including treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, adjustments, manipulation, or any form of physical therapy.

INITIAL ORTHOPEDIC PROSTHESIS EXPENSES: Prosthesis and corrective devices such as Durable Medical Equipment which are medically required as an integral part of treatment prescribed by a physician; Prosthesis/ Durable Medical Equipment does not include: motor driven wheelchairs or bed; comfort items such as telephone arms and over bed tables; items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners); disposable supplies; exercise cycles, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment, and similar items.

TRANSPORTATION BENEFITS

AMBULANCE SERVICE BENEFITS

Ambulance Service Benefits are provided for medically necessary emergency ground or air ambulance transportation as required from the emergency site to the nearest Hospital able to provide the required level of care. Coverage is not available if You are transported by Ambulance to a Hospital that doesn't result in You being Hospital Confined.

EMERGENCY MEDICAL EVACUATION

Benefits are payable if a Covered Person suffers a Sickness or Injury during the course of the Trip and the Hospital or Medical Facility they are at, in the opinion of the Assistance Provider, is unable to provide appropriate medical treatment, the Assistance Provider will coordinate an Emergency Medical Evacuation from the Hospital or Medical Facility where the Covered Person is at, to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained. An Emergency Medical Evacuation includes Medically Necessary medical treatment, medical services and medical supplies necessarily received in connection with such transportation.

Benefits will not be payable unless We authorize in writing or by an authorized electronic or telephonic means all expenses in advance. Benefits will not be payable unless: 1. the Physician ordering the Emergency Medical Evacuation certifies the severity of the Covered Person's Sickness or Injury requires an Emergency Medical Evacuation; 2. all transportation arrangements made for the Emergency Medical Evacuation are by the most direct and economical conveyance and route possible; 3. the charges incurred are Medically Necessary and do not exceed the usual level of charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred ; and 4. do not include charges that would not have been made if there were no insurance.

MEDICALLY NECESSARY REPATRATION

If You have been evacuated under the Emergency Medical Evacuation, or You are Hospitalized due to an Injury or a sudden and unexpected Sickness and it is determined by Your attending Physician and the Assistance Provider's Physician that You need to be medically repatriated back to a Hospital or medical facility in Your Country to recover, the Assistance Provider will coordinate a medical transfer, by any means necessary, to a Hospital or medical facility near Your home once your condition has reached maximum medical improvement.

Benefits will not be payable unless We authorize in writing or by an authorized electronic or telephonic means all expenses in advance. Benefits will not be payable unless: 1. the Physician ordering the Medically Necessary Repatriation certifies Your Sickness or Injury has reached maximum medical improvement; 2. all transportation arrangements made for the Medically Necessary Repatriation are by the most direct and economical conveyance and route possible; 3. the charges incurred are Medically Necessary and do not exceed the usual level of charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and 4. do not include charges that would not have been made if there were no insurance.

EMERGENCY REUNION

Benefits are payable for the cost of one economy airfare ticket and other local travel related expenses including the Reasonable Expenses incurred for lodging and meals of a Covered Person's Immediate Family Member, to join the Covered Person at the Hospital where the Covered Person is confined and to accompany the Covered Person back to their Home Country, if needed, provided: 1. the Emergency Medical Evacuation Benefit is payable under the Policy; 2. the Covered Person is alone outside of Their Home Country; 3 . the place of confinement is more than 100 miles from the Covered Person's Home Country; and 4. expenses were authorized in advance by the Company.

RETURN OF MINOR CHILDREN OR TRAVELING COMPANION

If the Covered Person is the only person traveling with minor Dependent children who are under the age of 21, or with a Travel Companion, and the Covered Person suffers a Sickness or Injury and must be Hospital Confined for at least 48 consecutive hours, or are medically evacuated to another location, benefits are payable for the cost of the Dependent or Travel Companion's one way economy airfare ticket and/or ground transportation ticket to Their Home Country. All transportation arrangements must be made by the most direct and economical route and conveyance possible and may not exceed the usual level of charges for similar transportation in the locality where the expense is incurred. Benefits will not be paid unless all expenses are approved in advance by Us, and services are rendered by the Assistance Provider.

REPATRIATION OF MORTAL REMAINS

Benefits are payable for preparation and return of a Covered Person's body to Their Home Country if they die due to a Sickness or Injury. Covered Expenses include Expenses for embalming or cremation; The least costly coffin or receptacle adequate for transporting the remains; Transporting the remains by the most direct and least costly conveyance and route possible. Expenses must be approved in advance and coordinated by the Assistance Provider.

LOCAL BURIAL / CREMATION

Benefits are payable for preparation, local burial or cremation of the Covered Person's mortal remains at the country of death in accordance with the commonly accepted cultural and religious beliefs practiced by the Covered Person. If the Local Cremation or Burial is chosen, the Return of Mortal Remains benefit will not apply. Expenses must be approved in advance by the Assistance Provider. Failure to utilize the Assistance Provider to approve these services will result in the denial of benefits. Coverage is not provided for burial and cremation costs incurred for: religious practitioner, flowers, music, food or beverages.

ADDITIONAL BENEFITS

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) – COMMON CARRIER

We will pay the Benefit Amount if the Covered person suffers one of the losses shown below within 365 days from riding in or on, boarding or alighting from any Common Carrier. The Benefit Amount is payable in addition to any other applicable Benefit Amounts under this Policy, with the exception of the Accident Death and Dismemberment – 24 hours and Accidental Death and Dismemberment – Felonious Assault, Violent Crime and Terrorist Incident. If multiple AD&D benefits are payable, the largest applicable AD&D benefit will be paid.

COVERED LOSS	**BENEFIT AMOUNT**
Loss of Life	100% of Principal Sum
Loss of Hands (Both), Loss of Feet (Both), or Loss of Sight of One Eye	100% of Principal Sum
Quadriplegia	100% of Principal Sum
Paraplegia	75% of Principal Sum
Hemiplegia	75% of Principal Sum
Loss of Hand, Loss of Foot or Loss of Sight of One Eye (any one of each)	50% of Principal Sum
Uniplegia	25% of Principal Sum
Loss of Thumb and Index Finger of the same hand	25% of Principal Sum

INCIDENTAL TRIPS OUTSIDE THE UNITED STATES

The Covered Person may take Incidental Trips outside the United States during their Policy Period. If a Covered Injury or Illness occurs while on their Incidental Trip, this benefit will pay to the maximum as outlined in the Schedule of Benefits for covered medical expenses incurred during the Incidental Trip. If the Covered Person's Injury or Illness require a Medical Evacuation or Medical Repatriation, from their destination, they will be evacuated back to their Home Country and not to the United States.

HOME COUNTRY COVERAGE

The Covered Person may return to their Home Country for up to 60 days per 12 months of Coverage Purchased during the Policy Period for an Incidental Trip. If a Covered Injury or Illness occurs while on their Incidental Trip, this benefit will pay to the maximum as outlined in the Schedule of Benefits for covered medical expenses incurred during the Incidental Trip. To be eligible for an Incidental Trip the Covered Person's Policy Period must be greater than 30 days in length. If the Covered Person does not return from their Incidental Trip on their scheduled return date, the Policy will be Terminated on the date of their scheduled return from their Home Country. If the Covered Person's scheduled return date cannot be verified, the Policy will terminate on the date the Covered Person departed for their Home

Country. Any Injury or Illness that occurred during the Incidental Trip will be considered a Pre-Existing Condition once the Incidental Trip has concluded and no further expenses for that Injury or Illness will be covered.

EXCLUSIONS

We will not pay for any Accidental Death and Dismemberment or Paralysis loss or Injury that is caused by, contributed by or that results from:

1. intentionally self-inflicted Injury.
2. suicide or any attempt thereat while sane or self-destruction or any attempt thereat while insane.
3. war or any act of war, whether declared or not.
4. service in the military, naval or air service of any country.
5. disease or bacterial infection except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food.
6. hernia of any kind.
7. piloting or serving as a crewmember or riding in any aircraft except as a passenger on a regularly scheduled or charter airline.
8. commission of, or attempt to commit, a felony.
9. Injury or Sickness that occurs while the Covered Person has been determined to be legally intoxicated as determined according to the laws of the jurisdiction in which the Injury or Sickness occurred, or under the influence of any narcotic, barbiturate, or hallucinatory drug, unless administered by a Doctor and taken in accordance with the prescribed dosage.
10. flying in any aircraft being used for or in connection with acrobatic or stunt flying, racing or endurance tests; flying in any rocket propelled aircraft; flying in any aircraft being used for or in connection with crop dusting, or seeding or spraying, firefighting, exploration, pipe or power line inspection, any form of hunting bird or fowl herding, aerial photography, banner towing or any test or experimental purpose; flying any aircraft which is engaged in flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even if granted.
11. All professional, semi-professional, amateur sports.
12. Interscholastic, Intramural, Recreational and Bodily Contact sports.
13. Adventure Activities, Mountaineering, Rock Climbing or Extreme Sports.

In addition to the Exclusions above, We will not pay Medical Expense Benefits, Transportation Benefits or Additional Benefits for any loss, treatment or services that is caused by, contributed by or that results from:

1. Pre-Existing Conditions, as defined, except as provided under the Acute Onset of a Pre-existing Condition.
2. Chronic Disease, that is not controlled or stable. Controlled and stable shall mean the Covered Person has adhered to their prescribed Treatment of their Chronic Disease up to the onset of the Covered Peron's Sickness.
3. declared or undeclared war or any act thereof.
4. services, supplies or treatment, including any period of Hospital confinement, which were not recommended, approved and certified as necessary and reasonable by a Physician.
5. payment for any subsequent medical services incurred for an Illness or Injury of the Covered Person leaving a medical facility against the medical advice of the attending Physician will not be covered for 90 days following the date the Covered Person left against medical advice of the Physician.
6. Sickness resulting from pregnancy.
7. miscarriage resulting from Accident.
8. immunizations, routine physical or other examinations where there are no objective indications or impairment in normal health, or laboratory diagnostic or x-ray examinations except in the course of a disability established by the prior call or attendance of a Physician, except as specifically provided for in this Policy.
9. cosmetic or plastic surgery, except as the result of an accident.

10. elective treatment, surgery, health treatment or examination that a) can be postponed until the Covered Person returns to his or her Home Country, b) is deemed by Us to be Experimental or Investigational, or c) are not recognized and generally accepted medical practices in the United States
11. any mental or nervous disorders or rest cures.
12. any dental treatment (except as provided by the for Dental Treatment for Injury).
13. eye refractions or eye examinations for the purpose of prescribing corrective lenses for eyeglasses or for the fitting thereof, unless caused by accidental bodily Injury incurred while covered under the Policy.
14. congenital anomalies and conditions arising out of or resulting therefrom.
15. services, supplies, or treatment expenses which are non-medical in nature.
16. the ordinary cost of a one-way airplane ticket used in the transportation back to the Covered Person's country where an air ambulance benefit is provided.
17. expenses as a result of or in connection with an intentionally self-inflicted Injury.
18. treatment paid for or furnished under any other individual or group policy, or other service or medical pre-payment plan arranged through an employer to the extent so furnished or paid, or under any mandatory government program or facility set up for treatment without cost to any individual.
19. childbirth, miscarriage, birth control, artificial insemination, treatment for fertility or impotency, sterilization or reversal thereof or abortion.
20. organ transplants, marrow procedures and chemotherapy.
21. any sexually transmitted or venereal disease; and/or any testing for the following: HIV, Vaccine induced seropositivity to the AIDS virus, AIDS related Illnesses, ARC Syndrome, AIDS.
22. any treatment, service or supply not specifically covered by the Policy.
23. treatment by any Family Member or member of the Covered Person's household.
24. treatment of hernia; Osgood-Schlatter's Disease; osteochondritis; osteomyelitis; congenital weakness whether or not caused by a Covered Accident.
25. expense incurred for treatment of temporomandibular or cranio-mandibular joint dysfunction and associated myofascial pain.
26. contact lenses, hearing aids, wheelchairs, braces, appliances, examinations or prescriptions for them, or repair or replacement of existing artificial limbs, orthopedic braces, orthotic devices, artificial eyes and larynx.
27. treatment or service provided by a private duty nurse or while confined primarily to receive custodial care, educational or rehabilitative care or nursing care.
28. covered medical expenses for which the Covered Person would not be responsible for in the absence of the Policy.
29. conditions that are not caused by a Covered Accident.
30. vocational, recreational, speech or music therapy.
31. traveling against the advice of a Physician, traveling while on a waiting list for inpatient Hospital or clinic treatment, or traveling for the purpose of obtaining medical treatment abroad.
32. any potential fatal condition which was diagnosed before the date your coverage became effective or any condition for which You are traveling to seek treatment.
33. Expenses incurred in your Home Country except as provided: under Benefit Period or under the Home Country Coverage.
34. any infection of the urinary tract (including, without limitation, infection of the kidney, ureter, bladder, prostate or urethra) and any complication, medical condition or other Illness directly or indirectly arising therefrom, that occurs within ninety (90) days of the Effective Date of this Insurance and that requires Treatment of the Covered Person in a Hospital as an inpatient.
35. declared or undeclared war or any act thereof.
36. Complications arising from or treatment of an Injury or Illness that is not covered under this Policy.
37. All professional, semi-professional, amateur sports.
38. Interscholastic, Intramural, Recreational and Bodily Contact sports.
39. Adventure Activities, Mountaineering, Rock Climbing or Extreme Sports.

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document.

“Accident” means a sudden, unexpected and unintended event that occurs while Your coverage is in effect.

“Acute Onset” means a sudden and unexpected outbreak or recurrence which occurs spontaneously and without advance warning.

“Appropriate Authority(ies)” means the government authority(ies) in the Covered Person’s Home Country or the government authority(ies) of the Host Country.

"Automobile" means a self-propelled, private passenger motor vehicle with four or more wheels that is a type both designed and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, sport utility vehicle, or a motor vehicle of the pickup, van, camper, or motor-home type. Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

“Cardiac Conditions” means medical conditions related to coronary disease, hypertension, high cholesterol/hyperlipidemia, congestive heart failure, arrhythmias, cardiomyopathy, valvular heart disease, congenital heart disease, and rheumatic heart disease. For the purpose of this definition a heart attack and myocardial infarction fall under the definition of Cardiac Conditions.

“Cardiovascular Event” shall mean any onset of a Cardiac Condition.

“Checked Baggage” means Personal Effects brought by You for planned use on Your Trip for which a claim check has been issued to You by a Common Carrier.

“Chronic Disease” means a medical condition that last 1 year or more and requires ongoing medical attention or limits activities of daily living or both.

“Company” means Crum & Forster SPC

“Covered Accident” means an Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Policy for which benefits are payable.

“Covered Expenses” means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies covered by the Policy. Coverage under the Policy must remain continuously in force from the date of the Accident or Sickness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

“Covered Loss” or “Covered Losses” means an accidental death, dismemberment or other Injury covered under the Policy.

“Covered Person” means any Insured and Dependent for whom the required premium is paid (herein also referred to as “You” or “Your” or “They” or “Their”).

"Deductible" means the dollar amount of Covered Expenses that must be incurred as an out of-pocket expense by each Covered Person per Policy Period. The Deductible must be met by the Covered Person before Medical Expense Benefits can be paid or reimbursed. The Deductible is applied to the first eligible claim processed.

“Dependent” means an Insured’s lawful spouse or domestic partner; or an Insured’s unmarried child, from the moment of birth to age 21, who is chiefly dependent on the Insured for support. A child, for eligibility purposes,

includes an Insured's natural child; adopted child, beginning with any waiting period pending finalization of the child's adoption; or a stepchild who resides with the Insured or depends chiefly on the Insured for financial support. A Dependent may also include any person related to the Insured by blood or marriage and for whom the Insured is allowed a deduction under the Internal Revenue Code. Insurance will continue for any Dependent child who reaches the age limit and continues to meet the following conditions: 1. the child is handicapped, 2. is not capable of self-support and 3. depends chiefly on the Insured for support and maintenance. The Insured must send Us satisfactory proof that the child meets these conditions, when requested. We will not ask for proof more than once a year.

"Designated Security Consultant" means an employee of a security firm under contract with Us or our Assistance Provider who is experienced in security and measures necessary to ensure the safety of the Covered Person(s) in his or her care.

"Effective Date" means the date coverage provided with respect to the Covered Person shall begin.

"Experimental" or "Investigational" means a service for which one or more of the following is true:

1. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings. We will determine if this item 1. is true based on:
    a. Published reports in authoritative medical literature; and
    b. Regulations, reports, publications, and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health and the Food and Drug Administration (FDA).
2. In the case of a drug, a device or other supply that is subject to FDA approval:
    a. It does not have FDA approval; or
    b. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off label use. Unlabeled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:
        i. Included in substantially accepted peer-reviewed medical literature such as: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Information, and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Included in a Prescription Drug reference compendium; or
        iii. In addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications.
3. The Provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to the board's approval.
4. Research protocols indicate that the service or supply is Experimental or Investigational. This item 4 applies for protocols used by the Covered Person's Provider as well as for protocols used by other Providers studying substantially the same service or supply.

"Evacuation Advisory" means a formal recommendation issued by the Appropriate Authorities that the Covered Person or citizens of his or her Home Country or Country of Residence or citizens of the Host Country leave the Host Country.

"Extreme Sports" means any high-risk non-team sport or recreation activity that is dangerous and if performed optimally, even by the highly skilled, risks loss of life or limb. Extreme Sports often involve speed, height, a high level of physical exertion and/or highly specialized gear.

“Health Care Plan” means a policy or other benefit or service arrangement for medical or dental care or treatment under: 1. group or blanket coverage, whether on an insured or self-funded basis; 2. Hospital or medical service organizations on a group basis; 3. Health Maintenance Organizations on a group basis; 4. group labor-management plans; 5. employee benefit organization plans; 6. association plans on a group or franchise basis; or 7. any other group employee welfare benefit plan as defined in the employee Retirement income Security Act of 1974, as amended.

"Home Country" means the country which the Covered Person has declared to Us in writing on their enrollment, as his or her true, fixed and permanent home and principal establishment.

“Hospital” means an institution that: 1. operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2. provides 24-hour nursing service by Registered Nurses on duty or call; 3. has a staff of one or more licensed physicians available at all times; 4. provides organized facilities for diagnosis, treatment and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5. is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such; and 6. is not a place solely for drug addicts, alcoholics, or the aged or any separate ward of the Hospital.

“Hospital Confined” means an overnight stay as a registered resident bed-patient in a Hospital.

“Host Country” means any country, other than an OFAC excluded country, in which the Covered Person is traveling while covered under the Policy.

“Immediate Family Member” means the spouse, parent, parent-in law, grandparent, child, grandchild, brother, sister, fiancé, aunt, uncle, niece or nephew, such person being related to the Covered Person.

"Illness” means Sickness.

“Incidental Trip“ means a short scheduled trip with a defined departure and return date prior to the start of the Incidental Trip, during their Policy Period. To be an eligible Incidental Trip, the Incidental Trip must take place after the Covered Person’s Effective Date and end prior to the Covered Person’s Termination Date.

“Inpatient” means a person who has been admitted to and charged by a Hospital for bed occupancy, for a period of at least overnight, for the purposes of receiving Inpatient Hospital services.

"Injury" means accidental bodily harm sustained by a Covered Person that results, directly and independently from all other causes, from a Covered Accident. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

“Medical Emergency” means a condition caused by an Injury or Sickness that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

“Medically Necessary” means a treatment, service or supply that is: 1. required to treat an Injury or Sickness; prescribed or ordered by a Physician or furnished by a Hospital; 2. performed in the least costly setting required by the Covered Person’s condition; and 3. consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. Purchasing or renting 1. air conditioners; 2. air purifiers; 3. motorized transportation equipment; 4. escalators or elevators in private homes; 5. eye glass frames or lenses; 6. hearing aids; 7. swimming pools or supplies for them; and 8. general exercise equipment are not considered Medically Necessary. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or

treatment alternative could have been used. We may, at Our discretion, consider the cost of the alternative to be the Covered Expense.

“Missing Bag Report” means a formal report of loss as filed with the common carrier commonly known as a PIR (Passenger Irregularity Report) or PAWOB (Passenger arriving without baggage). This must include the 6-digit Claim Number or the World Tracer Record Number as provided by the carrier.

“Missing Person” means a Covered Person who disappeared for an unknown reason and whose disappearance was reported to the Appropriate Authority(ies).

“Necessities” means personal hygiene items and clothing.

“Outpatient” means a person who received Medically Necessary treatment by a Physician or other healthcare provider and is not an Inpatient, regardless of the hour the person arrived at the Hospital, whether a bed was used, or whether the person remained in the Hospital past midnight.

“Policy Period” means the dates as shown on the Covered Person’s certificate for which premium has been paid.

“Pre-Existing Condition” means any medical condition, Sickness, Injury, Illness, disease, mental Illness or mental nervous disorder, for which medical advice, diagnosis, care or Treatment was recommended or received or for which a reasonably prudent person would have sought Treatment during the 36-month period immediately preceding the Effective Date of Coverage under this Policy.

Pre-Existing shall also mean any Injury, Illness, Sickness, disease, or other physical, medical, mental or nervous disorder, condition or ailment that, with reasonable medical certainty, existed at the time of Application or at any time during the 36 months prior to the Effective Date of this insurance, whether or not previously manifested, symptomatic or known, diagnosed, Treated, or disclosed to the Company prior to the Effective Date, and including any and all subsequent, chronic or recurring complications or consequences related thereto or resulting or arising therefrom.

Pre-Existing shall also include any Acute Onset of an Illness, Sickness, disease, or other physical, medical, mental or nervous disorder, condition or ailment that is an exacerbation of, due to, or associated with an underlying condition. Underlying condition shall include any condition that has been monitored by a Physician due to possible deterioration of the Covered Person’s diagnosis being changed, as a result of a previously known condition that can affect, degrade, and/or alter a Covered Person’s underlying condition, including any changes in medication.

“Reasonable Expenses” means any meal, lodging, local transportation and essential phone call expense that were necessarily incurred as the result of a covered event, and that were not provided free of charge or otherwise reimbursed by a Common Carrier, Travel Supplier or other party.

“Sickness” means an Illness, disease or condition of the Covered Person that: 1) requires a physical examination and medical treatment by a Physician; 2) commences, worsens or presents new symptoms while Your coverage is in effect; and 3) causes a loss for which a Covered Person incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

"Stroke” means a loss of blood flow to part of the brain, which causes damages to brain tissue. Types of strokes include but are not limited to Ischemic stroke, Hemorrhagic stroke and transient ischemic attack (TIA).

"Supplemental Restraint System" means an airbag that inflates upon impact for added protection to the head and chest areas.

“Termination Date" means the date coverage provided with respect to the Covered Person shall terminate.

“Transport” or “Transportation” means the most efficient and available method of conveyance. Where practical, economy fare will be utilized. If possible, the Covered Person’s common carrier tickets will be used.

“Traveling Companion” means a person or persons with whom the Covered Person has coordinated travel arrangements, shares the same accommodations as the Covered Person, and intends to travel with the Covered Person during the Trip.

“Trip” means travel by air, land, or sea from the Covered Person’s Home Country.

“Usual and Customary Charge” means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

“We”, “Our”, “Us” means The Company, or Crum & Forster SPC.

CLAIM PROCEDURES

All claims must be submitted within 90 days of the date of service. All claims MUST BE ON A FULLY COMPLETED claim form including medical history sections. A claim form must be completed and provided for each medical condition.

Governing Jurisdiction: All claims arising under this insurance shall be governed by the Laws of Cayman Islands whose courts alone shall have jurisdiction in any dispute arising hereunder.

Notice of Claim: A claimant must give Us or Our authorized representative written (or authorized electronic or telephonic) notice of claim within 90 days after any loss covered by the Policy occurs. If the claimant or Covered Person is incapacitated within the 90 days after the loss, must be given as soon as reasonably possible. This notice should identify the Covered Person and the Policy Number. All claims must be submitted within 90 days from date of incident, or they will be denied. Circumstances may exist in which this is not always possible. Any submissions after 90 days will be considered based on those circumstances.

Claim Forms: Upon receiving written notice of claim, We will provide claim forms to the claimant within 15 days. If We do not furnish such claim forms, the claimant will satisfy the requirements of written proof of loss by sending the written (or authorized electronic or telephonic) proof as shown below. The proof must describe the occurrence, extent and nature of the loss and give authorization to release medical records.

Proof of Loss: Written (or authorized electronic or telephonic) proof of loss must be sent to the agent authorized to receive it. Written (or authorized electronic or telephonic) proof must be given within 90 days after the date of loss. In no event, except in the absence of legal capacity, will proof of loss be accepted if it sent later than 90 days from the time proof is otherwise required.

Additional information may be requested if it is deemed necessary to complete the processing of any claim. Any additional information deemed necessary for the complete processing of any claim must be received from the insured person or any treating physician, hospital, or other health service provider within ninety (90) days from the date requested, otherwise, the claim will be processed with the information received within this timeframe.

Proof of Eligibility: A claimant must provide Us or Our authorized representative with written proof of eligibility as outlined in this policy, at time of Claim. Proof of Eligibility is required prior to any payment of a Claim.

Claimant Cooperation Provision: Failure of a claimant to cooperate with Us in the administration of a claim may result in the delay or termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Time Payment of Claims: Benefits for loss covered by the Policy, other than benefits that require periodic payment, will be paid not more than 60 days after We receive proper written proof of such loss.

Payment of Claims: If the Covered Person dies, any death benefits or other benefits unpaid at the time of the Covered Person's death will be paid to the beneficiary. If no beneficiary is on record with Us or Our authorized agent, payment will be made to the first surviving class of the following to the Covered Person's: 1. spouse; 2. children, in equal shares (If a child is a minor, benefits will be paid to the legal guardian); 3. mother or father; 4. estate. All other benefits due and not assigned will be paid to the Covered Person if living. Otherwise, the benefits may, at our option, be paid: 1. according to the beneficiary designation; or 2. to the Covered Person's estate. If a benefit due is payable to: 1.the Covered Person's estate; or 2. the Covered Person or a beneficiary who is either a minor or is not competent to give a valid release for the payment, We may pay any amount due to some other person. The other person will be one who we believe is entitled to the payment and who is related to the Covered Person or the beneficiary by blood or marriage. We will be relieved of further responsibility to the extent of any payment made in good faith. We may pay benefits directly to any Hospital or person rendering covered services, unless the Covered Person requests otherwise in writing. The Covered Person must make the request no later than the time he or she files a written proof of loss.

Recovery of Overpayment or Error: If benefits are overpaid, or paid in error, We have the right to recover the amount overpaid, or paid in error, by any or all of the following methods: 1. a request for lump sum payment of the amount overpaid or paid in error. 2. Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error. 3. Taking any other action available to Us. We may at Our own expense take proceedings in the name of the Covered Person to recover compensation or secure an indemnity from any third party in respect of any loss, damage or expense covered by this Insurance and any amount so recovered or secured shall belong to Us.

Assignment: At the request of the Covered Person or his or her parent or guardian, if the Covered Person is a minor, medical benefits may be paid to the provider of service. Any payment made in good faith will end our liability to the extent of the payment.

Beneficiary: The Insured may designate a beneficiary. The Insured has the right to change the beneficiary at any time by written (or electronic and telephonic) notice. If the Insured is a minor, his or her parent or guardian may exercise this right for him or her. The change will be effective when We or Our authorized agent receive it. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change. The Insured is the beneficiary for any covered Dependent.

Physical Examinations and Autopsy: We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

Legal Actions: No lawsuit or action in equity can be brought to recover on the Policy: 1. before 60 days following the date proof of loss was given to Us; or 2. After 3 years following the date proof of loss is required.

Not in Lieu of Workers' Compensation: The Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits.

Economic or Trade Sanctions: 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 https://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx.

Electronic Communication: 1. Consent to receive insurance related documents and communications, including but not limited to, your policy documents, disclosures, notices, explanation of benefits (EOB), claims documentation, as well as termination and cancellation or non-renewal notices, electronically to the email address you provide to us through the online application process instead of receiving these records in a paper format from us. 2. Agree and acknowledge that your consent is provided and/or obtained in connection with a transaction affecting interstate commerce subject to the Electronic Signatures in Global and National Commerce Act and the Uniform Electronic Transactions Act, or a similar electronic transactions law, as adopted by state law. 3. Agree that the document(s) delivered to you electronically shall have the same meaning and effect as if you were provided a paper document, whether or not you choose to view the document(s), unless you previously withdrew your consent to receive documents via electronic means as provided below. Electronic document(s) are considered received by you at the time you complete your purchase, unless we receive notice that the email notification was not delivered to you at the email address you provided.

Fraud Warning: If the Covered Person or any person acting on his/her behalf shall make any claim or statement knowing the same to be false or fraudulent as regards to amount or otherwise, then this Insurance shall become void and all claims here under shall be forfeited without refund of premium.

CONTACT INFORMATION

CLAIMS ADMINISTRATOR

Battleface on Behalf of Crum & Forster

For claim status or questions please call: Toll Free: 888-868-6053 / Direct: 860-831-4805

Email VenbrookTravel@RobinAssist.com

BATTLEFACE 24/7 TRAVEL ASSISTANCE SERVICES

The Travel Assistance program features a variety of emergency travel-related services that include Medical Monitoring Medical and Hospital Admission Guarantee. Travel assistance services are provided by an independent organization and not by the Company. There may be times when circumstances beyond Battleface's control hinder their endeavors to provide travel assistance services. They will, however, make all reasonable efforts to provide travel assistance services and help you resolve your emergency situation.

Toll Free: 888-868-6053 (within the United States and Canada)

Collect: 860-831-4805 (From all other locations)