



**TOKIOMARINE**  
**HCC**

**Medical Insurance Services Group**  
251 North Illinois Street, Suite 600, Indianapolis, IN, 46204 USA  
Tel: 317-262-2132 Fax: 317-262-2140 Toll Free: 800-605-2282  
<http://service.hccmis.com>  
hccmis.com

# WorldMed Inbound

DESCRIPTION OF COVERAGE

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# IMPORTANT NOTICE AND DISCLAIMER CONCERNING THE UNITED STATES PATIENT PROTECTION AND AFFORDABLE CARE ACT

This insurance is not subject to, and does not provide certain insurance benefits required by the United States' Patient Protection and Affordable Care Act ("PPACA"). PPACA requires certain US citizens or US residents to obtain PPACA compliant health insurance, or "minimum essential coverage." PPACA also requires certain employers to offer PPACA compliant insurance coverage to their employees. Tax penalties may be imposed on U.S. residents or citizens who do not maintain minimum essential coverage, and on certain employers who do not offer PPACA compliant insurance coverage to their employees. In some cases, certain individuals may be deemed to have minimum essential coverage under PPACA even if their insurance coverage does not provide all of the benefits required by PPACA. **You** should consult **your** attorney or tax professional to determine whether this policy meets any obligations **you** may have under PPACA.

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## DESCRIPTION OF COVERAGE SUMMARY

This Description of Coverage is a summary of the provisions contained in Master Policy No.191920-2.2. For a complete copy of the Master Policy, please contact Tokio Marine HCC - Medical Insurance Services Group.

This Description is to help **you** understand the insurance that **your** certificate provides. It details the key features, benefits, limitations, exclusions, definitions, Schedule of Benefits and Limits, and any endorsements, applying to **your certificate**.

The levels of coverage which apply to **your** coverage are detailed in the Schedule of Benefits and Limits.

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## IMPORTANT FEATURES OF YOUR TRAVEL INSURANCE

### CANCELLATION

**We** hope **you** are happy with the cover this policy provides. However, if after reading it, this insurance does not meet with **your** requirements, please notify **us** of **your** wish to cancel and **we** will refund **your** premium.

Premiums will be refunded in full if a cancellation request is received prior to the **certificate effective date**.

Premiums may be refunded after the **certificate effective date** subject to the following provisions:

- a. A \$25 cancellation fee will apply for administrative costs incurred by **us**; and
- b. Only the unused portion of the plan cost will be refunded; and
- c. **You** cannot have filed any claims to be eligible for a premium refund.

### U.S. PREFERRED PROVIDER ORGANIZATION (PPO)

This insurance policy offers the option of a PPO network for medical treatment received in the United States. If **you** choose to seek treatment from a PPO provider, billed charges for eligible expenses may be reduced and **we** will remit payment directly to the provider. Additionally, **we** will apply the in-network **coinsurance** applicable to the expenses.

**You** may review a listing of **hospitals, physicians** and other medical service providers included in the PPO Network for the area where **you** will be receiving treatment by accessing the Internet website for Tokio Marine HCC - MIS Group: [www.hccmis.com](http://www.hccmis.com). For assistance locating a provider, contact us at 1-800-605-2282.

## CLAIMS

This insurance policy has in it a Claims Procedure which tells **you** what steps **you** must take to file a claim, and explains **our** obligations to **you**. Beginning on the last day of **your certificate period**, **you** shall have **60 days** to provide us **proof of claim**.

## APPEALS AND COMPLAINTS

This insurance policy has in it an Appeals and Complaints Procedure which tells **you** what steps **you** can take if **you** wish to make an appeal or complaint.

## DEFINITIONS

This insurance policy has defined terms, indicated by bolded words (excluding headers). The defined terms may be found in the relevant benefit section or in the general definitions.

## PRE-EXISTING CONDITIONS

This insurance policy excludes coverage for pre-existing conditions, except as provided for under the Acute Onset of Pre-existing Conditions benefit. This policy defines a pre-existing condition and provides the description of the Acute Onset of Pre-Existing Conditions benefit.

## DATA PROTECTION

**We** respect individual privacy and value **your** confidence. **We** restrict access to personal information to employees/partners who need to know that information in order to perform their jobs. Any employee that **we** determine is in violation of this policy will be subject to disciplinary action, up to and including termination and criminal prosecution.

**We** will not disclose **your** personal information to third parties outside Tokio Marine HCC and **our** partners unless ordered to do so to comply with the law of the countries in which **we** do business or when complying with the legal process.

## RIGHTS OF THIRD PARTIES

**You** may assign benefits under this insurance to a **hospital, physician** or other provider. Any assignment shall not confer upon such **hospital, physician** or other provider, any right or privilege granted to **you** under this insurance except for the right to receive benefits, if any, which are determined to be due and payable hereunder. No **hospital, physician** or other provider shall have any direct or indirect claim or right of action against **us**.

## LAW AND JURISDICTION

No action of law or equity may be brought to recover benefits under this insurance until 60 days after written proof of claim has been provided to **us**. No such action may be brought after the end of three (3) years after the time written proof of claim is required to be furnished. The validity, interpretation, and performance of this agreement shall be governed by and construed in accordance with the laws of Bermuda.

## ARBITRATION

**EXCEPT FOR CERTAIN TYPES OF DISPUTES DESCRIBED IN THE “ARBITRATION AND CLASS ACTION WAIVER”, AND IF YOU DO NOT OPT-OUT AS SET FORTH IN THAT SAME SECTION, YOU AGREE THAT DISPUTES BETWEEN YOU AND THE TOKIO MARINE HCC - MIS GROUP AND/OR THE UNDERWRITERS WILL BE RESOLVED BY BINDING, INDIVIDUAL ARBITRATION, AND YOU WAIVE YOUR RIGHT TO BRING OR RESOLVE ANY DISPUTE AS, OR PARTICIPATE IN, A CLASS, CONSOLIDATED, REPRESENTATIVE, COLLECTIVE, OR PRIVATE ATTORNEY GENERAL ACTION OR ARBITRATION.**

## TOKIO MARINE HCC - MEDICAL INSURANCE SERVICES GROUP (“MIS GROUP”)

A subsidiary of Tokio Marine HCC, HCC Lloyd’s Syndicate 4141 is managed by HCC Underwriting Agency Ltd which is authorized by the Prudential Regulation Authority (PRA) and regulated by the Financial Conduct Authority (FCA) and the PRA. Registered in England and Wales No. 04632146. Registered office: 1 Aldgate, London EC3N 1RE, United Kingdom. Lloyd’s is authorised as an insurer in Spain by the Spanish insurance regulatory authority (Dirección General de Seguros y Fondos de Pensiones) under reference L0017.

These details can be checked on the Financial Services Register by visiting: [www.fca.org.uk](http://www.fca.org.uk) or contacting the Financial Conduct Authority on 0800 111 6768.

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## MEMBER ELIGIBILITY

Non-U.S. Citizens who are at least 14 days of age and under age 70 and that are traveling outside of their home countries.

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## CERTIFICATE EFFECTIVE & TERMINATION DATES

### CERTIFICATE EFFECTIVE DATE

Insurance hereunder is effective on the later of:

- a. The moment **we** receive an application and correct premium if the application and payment is made online or by fax;
- b. 12:01am U.S. Eastern Time on the date we receive an application and correct premium if the application and payment is made by mail;
- c. The moment **you** depart from **your home country**; or
- d. 12:01am U.S. Eastern Time on the date requested on the application.

### CERTIFICATE TERMINATION DATE

Insurance hereunder terminates on the earlier of:

- a. 11:59pm U.S. Eastern Time on the last day of the period for which premium has been paid;
  - b. 11:59pm U.S. Eastern Time on the date requested on the application; or
  - c. The moment of arrival upon **your** return to **your home country** (unless **you** have started a benefit period or are eligible for home country coverage).
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## BENEFIT PERIOD & HOME COUNTRY COVERAGE

### BENEFIT PERIOD

While the **certificate** is in effect, the benefit period does not apply. Upon termination of the **certificate**, in accordance with this provision, **we** will pay eligible medical expenses for up to 90 days beginning on the first day of diagnosis or treatment of a covered **injury** or **illness** while **you** are outside **your home country**. The benefit period applies only to eligible medical expenses related to the **injury** or **illness** that began while the **certificate** was in effect.

In the event **you** begin a benefit period while the **certificate** is in effect, and the **certificate** terminates because **you** return to **your home country**, **we** will pay eligible medical expenses which are incurred in **your home country** during the benefit period. Home country coverage applies only to eligible medical expenses related to the **injury** or **illness** that began while the **certificate** was in effect.

### INCIDENTAL HOME COUNTRY COVERAGE

For every three-month period during which **you** are covered, eligible medical expenses incurred in **your home country** are covered up to a maximum of 30 days.

Any benefit accrued under a single three-month period does not accumulate to another period. Failure to continue **your** international trip or **your** return to **your home country** for the sole purpose of obtaining treatment for an **illness** or **injury** that began while traveling shall void any home country coverage provided under the terms of this agreement.

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Except for a benefit period, coverage provided under this Master Policy is for a maximum duration of 364 days.

Notwithstanding the foregoing, coverage under all plans shall terminate on the date **we**, at **our** sole option, elect to cancel all **members** of the same sex, age, class or geographic location, provided **we** give no less than 30 days advance written notice by mail to **your** last known address.

## SCHEDULE OF BENEFITS AND LIMITS

Plan Details	
Overall Maximum Limit	\$500,000 or \$1,000,000
Maximum per Injury / Illness	\$500,000, or \$1,000,000
Deductibles	\$0, \$250, \$500, or \$1,000 per <b>certificate period</b>
Coinsurance – Claims incurred outside U.S.	<b>We</b> will pay 100% of eligible expenses after the deductible up to the overall maximum limit.
Coinsurance – Claims incurred in U.S.	
In-Network Payment	<b>Within the PPO:</b> <b>We</b> will pay 100% of eligible expenses, after the deductible, to the overall maximum limit.
Out-of-Network Payment	<b>Outside the PPO: Usual, reasonable, and customary. You</b> may be responsible for any charges exceeding the payable amount.

Eligible expenses are subject to **deductible, coinsurance, overall maximum limit, and are per certificate period** unless specifically indicated otherwise.

Benefit	Limit
Hospital Room and Board	Average semi-private room rate, including nursing services
Intensive Care Unit	Up to the overall maximum limit
Local Ambulance	<b>Usual, reasonable and customary</b> charges, when covered <b>illness</b> or <b>injury</b> results in hospitalization as inpatient.
Emergency Room Co-payment	<u>Claims incurred outside the U.S.</u> No co-payment <u>Claims incurred in U.S.</u> <b>You</b> shall be responsible for a \$250 co-payment for each use of emergency room for an <b>illness</b> unless <b>you</b> are admitted to the <b>hospital</b> . There will be no co-payment for emergency room treatment of an <b>injury</b> .
Urgent Care Center Co-payment	<u>Claims incurred outside the U.S.</u> No co-payment <u>Claims incurred in U.S.</u> For each visit, <b>you</b> shall be responsible for a \$50 co-payment, after which coinsurance will apply. – <i>Co-payment is waived for <b>members</b> with a \$0 deductible.</i> – <i>not subject to deductible</i>
Outpatient Physical Therapy and Chiropractic Care	<b>Usual, reasonable and customary</b> charges. Must be ordered in advance by a <b>physician</b> .
Mental Health Disorders	Up to \$5,000
Emergency Dental Treatment due to Accident	Up to \$1,000

Emergency Dental ( <i>Acute Onset of Pain</i> )	Up to \$100 - <i>not subject to deductible or coinsurance</i>
Acute Onset of Pre-existing Condition ( <i>excludes chronic and congenital conditions</i> )	Ages 65 and above: \$2,500 All others: \$20,000
Terrorism	Up to \$50,000 lifetime maximum, eligible medical expenses only
Optional Hazardous Activities Rider	Up to the overall maximum limit
Optional Intercollegiate or Interscholastic Sports Rider	Up to \$20,000
All Other Eligible Medical Expenses	Up to the overall maximum limit
<b>Emergency Travel Benefits</b>	<b>Limit</b>
Emergency Medical Evacuation	Up to \$250,000 lifetime maximum - <i>not subject to deductible, coinsurance, or overall maximum limit</i>
Repatriation of Remains	Up to \$50,000 - <i>not subject to deductible, coinsurance, or overall maximum limit</i>
Emergency Reunion	Up to \$15,000, subject to a maximum of 15 days - <i>not subject to deductible or coinsurance</i>
Return of Minor Children	Up to \$50,000 - <i>not subject to deductible or coinsurance</i>
Political Evacuation	Up to \$50,000 lifetime maximum - <i>not subject to deductible or coinsurance</i>
Trip Interruption	Up to \$5,000 - <i>not subject to deductible or coinsurance</i>
Accidental Death & Dismemberment  Ages 18 through 69  Under age 18	Lifetime Maximum - \$50,000 Death - \$50,000 Loss of 2 Limbs - \$50,000 Loss of 1 Limb - \$25,000  Lifetime Maximum - \$5,000 Death - \$5,000 Loss of 2 Limbs - \$5,000 Loss of 1 Limb - \$2,500  \$250,000 maximum benefit any one family or group. <i>- not subject to deductible, coinsurance, or overall maximum limit</i>
Optional Enhanced Accidental Death & Dismemberment Rider	Lifetime Maximum - \$50,000 Death - \$50,000 Loss of 2 Limbs - \$50,000 Loss of 1 Limb - \$25,000 <i>- not subject to deductible, coinsurance, or overall maximum limit</i>
Lost Checked Luggage	Up to \$500 - <i>not subject to deductible or coinsurance</i>
Lost or Stolen Passport/Travel Visa	Up to \$100 - <i>not subject to deductible or coinsurance</i>
Natural Disaster - Replacement Accommodations	Up to \$100 a day for 5 days - <i>not subject to deductible or coinsurance</i>
Hospital Indemnity	\$100 per day for 5 days for <b>inpatient</b> hospitalization - <i>not subject to deductible or coinsurance</i>



Personal Liability	Up to: \$10,000 lifetime maximum \$10,000 <b>third person injury</b> \$10,000 <b>third person</b> property \$2,500 <b>related third person</b> property <i>- not subject to deductible, coinsurance, or overall maximum limit</i>
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**Certificate Period** means the period of time beginning on the date and time of the **certificate effective date** and ending on the date and time of the **certificate termination date**.

**Coinsurance** means **your** payment of eligible expenses as specified in the Schedule of Benefits and Limits.

**Deductible** means the dollar amount of eligible expenses, specified in the Schedule of Benefits and Limits that **you** must pay per **certificate period** before eligible expenses are paid.

**Usual, Reasonable and Customary** means the lesser of the following:

1. One and a half times (150%) of the charges payable under the United States Medicare program, for claims incurred outside the PPO network within the U.S., or
2. Most common charge for similar services, medicines or supplies within the area in which the charge is incurred, so long as those charges are reasonable. What is defined as **usual, reasonable and customary** charges will be determined by **us**. In determining whether a charge is **usual, reasonable and customary**, **we** may consider one or more of the following factors: the level of skill, extent of training, and experience required to perform the procedure or service; the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services; the severity or nature of the **illness** or **injury** being treated; the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country; the cost to the provider of providing the service, medicine or supply; such other factors **we**, in the reasonable exercise of discretion, determine are appropriate.

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## U.S. PREFERRED PROVIDER ORGANIZATION (PPO) REQUIREMENTS

Nothing contained in this insurance restricts or interferes with **your** right to select the **hospital, physician** or other medical service provider of **your** choice. Nothing contained in this insurance restricts or interferes with the relationship between **you** and the **hospital, physician** or other providers with respect to treatment or care of any condition, nor **your** right to receive, at **your** own expense, services and/or supplies that are not covered under this insurance.

To comply with the United States Preferred Provider Organization (PPO) requirements, **you** must receive medical treatment from PPO providers while in the United States. If **you** choose to seek treatment from a PPO provider, **we** will remit payment for eligible expenses directly to the provider and **we** will waive the **coinsurance** applicable to the expenses.

**You** may review a listing of **hospitals, physicians** and other medical service providers included in the PPO Network for the area where **you** will be receiving treatment by accessing the Internet website for Tokio Marine HCC - MIS Group at: [www.hccmis.com](http://www.hccmis.com). For assistance locating a provider, contact us at 1-800-605-2282.

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## CLAIM PROCEDURES

**You** must submit a claim for any expenses to be paid by **us**. This includes treatment or services for which the medical provider will bill **us** directly. No payments will be made by **us** without **you** first submitting a claim.

Notice of claim, Claimant's Statement and Authorization, and proof of claim must be mailed to:



Tokio Marine HCC - MIS Group  
P.O. Box 2005  
Farmington Hills, MI 48333-2005  
USA

### **PROOF OF CLAIM**

When **we** receive notice of a claim, **we** will provide **you** with forms for filing proof of claim. The following is considered to be proof of claim:

1. A completed and signed Claimant's Statement and Authorization form, together with any/all required attachments;
2. Original itemized bills from **physicians, hospitals** and other medical providers; and
3. Original receipts for any expenses which have already been paid by **you** or on **your** behalf.

Beginning on the last day of **your certificate period**, **you** shall have **60 days** to provide us **proof of claim** (unless medical services were rendered after the certificate termination date, in which case **you** shall have 60 days from the date the claim is incurred). Subsequent to receipt of **proof of claim**, **we** may, at **our** sole discretion, request and require additional information, including but not limited to medical records, necessary to confirm the validity of any claim prior to payment thereof.

### **CLAIMS COOPERATION**

**You** shall provide assistance and cooperate with **us** or **our** representatives in obtaining any other records **we** or they feel necessary to evaluate the incident or claim. Following notification of a claim, **you** shall provide, when asked, all authorizations necessary to obtain **your** medical records. If **you** do not cooperate with **us** and/or **our** investigation of the claim, **we** shall not be liable to pay any claim.

### **ACCESS TO ADDITIONAL MATERIALS**

**You** shall provide **us**, or **our** designated representatives, all information, documentation, medical information that **we** or they may reasonably require during the term of this policy, or until all claims have been resolved, whichever is later.

### **OTHER INSURANCE**

**We** shall not pay any claim if there is other insurance which would, or would but for the existence of this insurance, pay such claim. This insurance will apply with respect to expenses in excess of the amount paid or payable under such other insurance. **We** shall not pay any claim in respect to care, treatment, services or supplies furnished by any program or agency funded by any government.

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## **APPEAL AND COMPLAINTS PROCEDURE**

### **APPEALING A CLAIM**

In the event **we** deny all or part of a claim under this insurance, **you** may file a written appeal with **us**. The written appeal must include sufficient information to identify the claim under appeal and must specify the reason(s) for the appeal with supporting documentation, if applicable. Please provide your written appeal online or by postal mail at the following:

<http://service.hccmis.com/> or Tokio Marine HCC - MIS Group  
P.O. Box 2005  
Farmington Hills, MI 48333-2005  
USA

When **we** receive the appeal, **we** will review the claim and a written response will be sent to **you**. After **you** receive **our** response to the appeal, **you** may initiate a second appeal. With **our** receipt of the second appeal, medical and/or claims personnel who were not involved in the original claim determination or the initial appeal will review the claim. A final determination will be made and a letter will be sent to **you**.

**Please note that appealing a claim is not a requirement to following the complaints procedure detailed below.**

## **COMPLAINTS PROCEDURE**

**We** are dedicated to providing a high-quality service and want to ensure that it is maintained at all times. If **you** feel that **we** or another party connected with this policy have not offered a first class service please contact **us** and **we** will do our best to resolve the problem.

Please provide your written complaint online or by postal mail at the following:

<http://service.hccmis.com/> or Tokio Marine HCC - MIS Group  
P.O. Box 2005  
Farmington Hills, MI 48333-2005  
USA

**You** will be contacted within 3 (three) business days of receiving **your** complaint to inform **you** of what action is being taken. **We** will try to resolve the problem and give **you** an answer within four weeks. If it will take longer than four weeks **we** will tell **you** when **you** can expect an answer.

If **you** are a UK citizen and **you** have not been given an answer within 8 (eight) weeks or should you remain dissatisfied, **you** may if **you** wish, refer **your** complaint to Lloyd's, who will investigate and assess **your** complaint. Lloyd's contact details are as follows:

Complaints  
Lloyd's  
One Lime Street  
London EC3M 7HA

Email: [complaints@lloyds.com](mailto:complaints@lloyds.com)  
Telephone: +44 (0)20 7327 5693  
Fax: +44 (0)20 7327 5225  
Web: [www.lloyds.com/complaints](http://www.lloyds.com/complaints)

This complaints procedure does not affect any legal right **you** have to take action. Once **you** have received **your** final response from Lloyd's, and if **you** are still not satisfied **you** can contact the Financial Ombudsman Service:

Financial Ombudsman Service  
Exchange Tower, Harbour Exchange Square, London, E14 9SR  
Phone: +44 (0) 20 7964 0500  
Email: [complaint.info@financial-ombudsman.org.uk](mailto:complaint.info@financial-ombudsman.org.uk)

If you have purchased your policy online or by other electronic means within the European Union (EU) you may also make your complaint via the EU's online dispute resolution (ODR) platform. The website for the ODR platform is: <http://ec.europa.eu/odr>

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## **ARBITRATION AND CLASS ACTION WAIVER**

Excluding claims for injunctive or other equitable relief, any dispute or controversy between a Member and any of the MIS Group, Underwriters or their affiliates arising out of or relating to this Master Policy, including without limitation, any and all disputes, claims (whether in tort, contract, statutory or otherwise) or disagreements concerning the existence, breach, interpretation, application or termination of this Master Policy, shall be resolved by final and binding arbitration pursuant to the Federal Arbitration Act and in accordance with the JAMS Inc. Comprehensive Arbitration Rules & Procedures then in effect. Such claims shall be arbitrated on an individual basis only and the parties waive any right or authority for any claims to be resolved in a class, consolidated, representative, collective or private attorney general action or arbitration. The arbitration shall take place in [Houston, Texas] or at the option of the party seeking relief, by telephone, online, or via written submissions alone, and be administered by JAMS. The arbitral tribunal ("Tribunal") shall be composed of one arbitrator, who shall be independent and impartial. If the parties fail to agree on

the arbitrator within twenty (20) calendar days after the initiation of an arbitration hereunder, JAMS shall appoint the arbitrator. The arbitration shall be conducted in the English language. The decision of the arbitrator will be final and binding on the parties. Judgment on any award(s) rendered by the arbitrator may be entered in any court having jurisdiction thereof. The arbitrator shall have the authority to determine arbitrability of any disputes arising out of or relating to this Master Policy. Nothing in this Section shall prevent either party from seeking immediate injunctive relief from any court of competent jurisdiction, and any such request shall not be deemed incompatible with the agreement to arbitrate or a waiver of the right to arbitrate. The parties undertake to keep confidential all awards in their arbitration, together with all confidential information, all materials in the proceedings created for the purpose of the arbitration and all other documents produced by the other party in the proceedings and not otherwise in the public domain, save and to the extent that disclosure may be required of a party by legal duty, to protect or pursue a legal right or to enforce or challenge an award in legal proceedings before a court or other judicial authority. The arbitrator shall award all fees and expenses, including reasonable attorney's fees, to the prevailing party. This agreement to arbitrate does not apply to claims Members may have for medical malpractice against their medical providers.

Members may choose to opt out of the agreement to arbitrate by mailing a written opt-out notice ("Notice") to Tokio Marine HCC – MIS Group. The Notice must be postmarked no later than sixty (60) days after the last day of your certificate period. The Notice must be mailed to: HCC Insurance Holdings, 13403 NW Freeway, Houston, Texas 77040, to the attention of General Counsel. This procedure is the only mechanism by which you can opt out of the agreement to arbitrate. Opting out of the agreement to arbitrate has no effect on any other parts of this Master Policy, or any previous or future arbitration agreements that you have entered into with Tokio Marine HCC – MIS Group.

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## PRE-EXISTING MEDICAL CONDITIONS

This policy does not cover **pre-existing conditions**, except charges resulting directly from an Acute Onset of Pre-existing Condition subject to the limits set forth in the Schedule of Benefits and Limits.

**Pre-existing Condition** means any

1. Condition for which medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) was recommended or received during the 18 months immediately preceding the certificate effective date;
2. Condition that had manifested itself in such a manner that would have caused a reasonably prudent person to seek medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) within the 18 months immediately preceding the certificate effective date; or
3. **Injury, illness**, sickness, disease, or other physical, medical, mental, or nervous conditions, disorder or ailment (whether known or unknown) that, with reasonable medical certainty, existed at the time of application or within the 18 months immediately preceding the certificate effective date. For the purposes of the Complications of Pregnancy coverage offered hereunder, pregnancy will not be included within the definition of a **pre-existing condition**.

## ACUTE ONSET OF PRE-EXISTING CONDITION

### **YOU ARE COVERED:**

1. Charges for a sudden and unexpected outbreak or recurrence of a **pre-existing condition(s)** which:
  - a. Occurs spontaneously and without advance warning either in the form of **physician** recommendations or symptoms; and
  - b. Is of short duration; and
  - c. Is rapidly progressive; and
  - d. Requires urgent care.

**YOU ARE NOT COVERED** unless **you** fulfill the following condition:

1. Treatment must be obtained within 24 hours of the sudden and unexpected outbreak or recurrence.

#### **YOU ARE NOT COVERED IF:**

1. The Acute Onset of a Pre-existing Condition(s) occurs before the certificate effective date; or
2. The pre-existing condition is a chronic or congenital condition or that gradually becomes worse over time; or
3. The charges are for known, scheduled, required, or expected medical care, drugs or treatments existent or necessary prior to the certificate effective date; or
4. Expenses arise directly or indirectly from anything in the General Exclusions.

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## MEDICAL & REPATRIATION EXPENSES

Subject to the limits set forth in the Schedule of Benefits and Limits, and subject to the conditions and restrictions contained in this provision, **we** will pay the following expenses incurred while this insurance is in effect.

### **MEDICAL EXPENSES**

#### **YOU ARE COVERED:**

1. Charges made by a **hospital** for:
  - a. Daily room and board and nursing services not to exceed the average semi-private room rate; and
  - b. Daily room and board and nursing services in Intensive Care Unit; and
  - c. Use of operating, treatment or recovery room; and
  - d. Services and supplies which are routinely provided by the hospital to persons for use while inpatients; and
  - e. Emergency treatment of an **injury**, even if **hospital** confinement is not required; and
  - f. Emergency treatment of an **illness**; subject to emergency room co-pay as outlined in the Schedule of Benefits and Limits. ER co-payment is waived when **you** are directly admitted to the **hospital** as **inpatient** for further treatment of that **illness**.
2. **Surgery** at an **outpatient** surgical facility, including services and supplies.
3. Charges made by a **physician** for professional services, including **surgery**. Charges for an assistant surgeon are covered up to 20% of the **usual, reasonable and customary** charge of the primary surgeon, but standby availability will not be deemed to be a professional service and therefore is not covered hereunder.
4. Dressings, sutures, casts or other supplies which are **medically necessary** and administered by or under the supervision of a **physician**, but excluding nebulizers, oxygen tanks, diabetic supplies, other supplies for use or application at home, and all devices or supplies for repeat use at home, except **durable medical equipment**.
5. Diagnostic testing using radiology, ultrasonographic or laboratory services (psychometric, intelligence, behavioral and educational testing are not included).
6. Artificial limbs, eyes or larynx, breast prosthesis or basic functional artificial limbs, but not the replacement or repair thereof.
7. Reconstructive **surgery** when the **surgery** is directly related to **surgery** which is covered hereunder.
8. Hemodialysis and the charges by the **hospital** for processing and administration of blood or blood components but not the cost of the actual blood or blood components.
9. Oxygen and other gasses and their administration by or under the supervision of a **physician**.
10. Anesthetics and their administration by a **physician**.
11. Drugs which require prescription by a **physician** for treatment of a covered **injury** or **illness**, but not for the replacement of lost, stolen, damaged, expired or otherwise compromised drugs, and for a maximum supply of 60 days per prescription.
12. Care in a licensed **extended care facility** upon direct transfer from an acute care **hospital**.

13. **Home nursing care** in bed by a qualified licensed professional, provided by a **home health care agency** upon direct transfer from an acute care **hospital** and only in lieu of **medically necessary inpatient** hospitalization.
14. Emergency local ambulance transport necessarily incurred in connection with **injury** or **illness** resulting in **inpatient** hospitalization.
15. Emergency dental treatment and dental **surgery** necessary to restore or replace sound natural teeth lost or damaged in an **accident** which was covered under this insurance.
16. Emergency dental treatment necessary to resolve **acute onset of pain**, provided treatment is obtained within 24 hours of the **acute onset of pain**.
17. **Medically necessary** rental of **durable medical equipment** (consisting of a standard basic hospital bed and or a standard basic wheelchair) up to the purchase prices.
18. Outpatient physical therapy or chiropractic care if prescribed by a **physician** who is not affiliated with the physical therapy or chiropractic practice, necessarily incurred to continue recovery from a covered **injury** or **illness**.
19. **Injury** or **illness** resulting from participation in sports or athletic activities not otherwise excluded under this insurance.

**YOU ARE NOT COVERED IF:**

1. Expenses arise directly or indirectly from anything in the General Exclusions.

**EMERGENCY MEDICAL EVACUATION**

**YOU ARE COVERED:**

1. Emergency air transportation to a suitable airport nearest to the **hospital** where **you** will receive treatment; and
2. Emergency ground transportation necessarily preceding emergency air transportation; and from the destination airport to the **hospital** where **you** will receive treatment.

**YOU ARE NOT COVERED** unless **you** fulfill the following conditions:

1. The evacuation is recommended by the attending **physician** who certifies that it is **medically necessary** and that transportation by any other method would result in the loss of **your** life or limb; and
2. The evacuation is agreed upon by **you** or **your relative**; and
3. Travel arrangements, excluding Emergency Local Ambulance, are approved in advance and coordinated by **us**.

**YOU ARE NOT COVERED IF:**

1. The **illness** or **injury** giving rise to the expense is not covered under this insurance; or
2. **Medically necessary** treatment, services and supplies can be provided locally; or
3. If transportation by any other method would not result in the loss of **your** life or limb; or
4. The condition giving rise to the Emergency Medical Evacuation did not occur spontaneously and without advance warning, either in the form of **physician** recommendation or symptoms which would have caused a prudent person to seek medical attention prior to the onset of the emergency; or
5. Expenses are directly or indirectly from anything in the General Exclusions.

**We** will provide Emergency Medical Evacuation only to the nearest **hospital** that is qualified to provide the **medically necessary** treatment, services and supplies to prevent **your** loss of life or limb.

The timeliness of arrangements can be affected by circumstances which are not within **our** control such as: availability of transportation equipment and staff, delays or restrictions on flights caused by mechanical problems, government officials, telecommunications problems, weather and other acts of God. **We** shall not be held liable for any delays that are not within **our** direct and immediate control.

Notwithstanding the foregoing, and if **you** are visiting the U.S., **we** will pay for expenses to return **you** to **your home country** if the attending **physician** and **our** medical consultant agree that transfer to **your home country** is more appropriate than transfer to the nearest qualified **hospital**.

## **TRIP INTERRUPTION**

### **YOU ARE COVERED:**

1. The cost of an economy one-way air or ground transportation ticket for you to the terminal serving the area of **your** principal residence, and/or
2. The cost of an economy one-way air and/or ground transportation ticket for **you** from the area where **you** were hospitalized following an Emergency Medical Evacuation to the area where **you** were initially evacuated from or to the terminal serving the area of **your** principal residence.

**YOU ARE NOT COVERED** unless **you** fulfill the following conditions:

1. **You** provide proof of one or more of the following events: destruction, after departure from **home country**, resulting from fire or weather of more than 40% of **your** principal residence, or death of a parent, spouse, sibling, child, or grandchild; or
2. Following a covered Emergency Medical Evacuation, the attending **physician** states that it is **medically necessary** for **you** to return to **your home country** or to the area from which **you** were initially evacuated for continued treatment, recuperation and recovery.

### **YOU ARE NOT COVERED IF:**

1. Expenses arise directly or indirectly from anything in the General Exclusions.

## **RETURN OF MINOR CHILDREN**

### **YOU ARE COVERED:**

1. The cost of a one-way economy air and/or ground transportation ticket for each covered minor child to the terminal serving the area of the principle residence of each minor child.

**YOU ARE NOT COVERED** unless **you** fulfill the following conditions:

1. **You** are the only person age 18 or older, traveling with one or more minor children under the age of 18 who are also covered hereunder; and
2. **You** are hospitalized for treatment of a covered **illness** or **injury**, resulting in the children being left unattended for a period of time expected to exceed 36 hours; and
3. The Return of Minor Children benefit must be agreed upon by **you** and/or by an authorized adult **relative** of the affected, covered minor children.

### **YOU ARE NOT COVERED IF:**

1. Expenses arise directly or indirectly from anything in the General Exclusions.

The timeliness of arrangements can be affected by circumstances which are not within **our** control such as: availability of transportation equipment and staff, delays or restrictions on flights caused by mechanical problems, government officials, telecommunications problems, weather and other acts of God. **We** shall not be held liable for any delays that are not within **our** direct and immediate control.

## **POLITICAL EVACUATION**

### **YOU ARE COVERED:**

1. The cost of transportation by the most economical means possible for **you** to the nearest country of safety or to **your home country**. **We** will determine to which country **you** will be evacuated.

**YOU ARE NOT COVERED** unless **you** fulfill the following conditions:

1. The U.S. Department of State has issued a level 3 or level 4 travel advisory after **your** arrival in the destination country; and



2. **You** contact **us** within 10 days of the date the travel advisory is issued.

**YOU ARE NOT COVERED IF:**

1. Expenses arise directly or indirectly from anything in the General Exclusions.

## **REPATRIATION OF REMAINS**

**YOU ARE COVERED:**

1. Air or ground transportation of bodily remains or ashes to the airport or ground transportation terminal nearest **your** principal residence; and
2. Reasonable costs of preparation of the remains necessary for transportation.

**YOU ARE NOT COVERED** unless **you** fulfill the following conditions:

1. The **illness** or **injury** giving rise to the expense are covered under this insurance; and
2. Travel arrangements are approved in advance and coordinated by **us**.

**YOU ARE NOT COVERED IF:**

1. Expenses arise directly or indirectly from anything in the General Exclusions.

**We** are held harmless and shall not be held liable for loss of or any damage or other impairment to bodily remains incurred during the repatriation process or otherwise.

The timeliness of arrangements can be affected by circumstances which are not within **our** control such as: availability of transportation equipment and staff, delays or restrictions on flights caused by mechanical problems, government officials, telecommunications problems, weather and other acts of God. **We** shall not be held liable for any delays that are not within **our** direct and immediate control.

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## **INDEMNITY BENEFIT & VISITATION EXPENSES**

### **HOSPITAL INDEMNITY**

**YOU ARE COVERED:**

1. The Hospital Indemnity benefit for each night **you** spend in the hospital.

**YOU ARE NOT COVERED** unless **you** fulfill the following conditions:

1. **You** must provide verification of an eligible **inpatient** hospitalization.

**YOU ARE NOT COVERED IF:**

1. Expenses arise directly or indirectly from anything in the General Exclusions.

### **EMERGENCY REUNION**

**YOU ARE COVERED:**

1. The cost of an economy round-trip air or ground transportation ticket for one **relative** for transportation to the terminal serving the area where **you** are hospitalized or are to be hospitalized following Emergency Medical Evacuation; and
2. Reasonable expenses for lodging and meals for the **relative**, which are incurred in the area where **you** are hospitalized for a period not to exceed 15 days.

**YOU ARE NOT COVERED** unless **you** fulfill the following conditions:

1. **You** have a covered Emergency Medical Evacuation.

**YOU ARE NOT COVERED IF:**

1. Expenses arise directly or indirectly from anything in the General Exclusions.



# TRAVEL ASSISTANCE

## LOST CHECKED LUGGAGE

### **YOU ARE COVERED:**

1. Replacement of clothes and personal hygiene items, not to exceed \$50 any one item.

### **YOU ARE NOT COVERED** unless **you** fulfill the following conditions:

1. The lost checked luggage must have been checked, in accordance with routine luggage checking procedures, for transportation with **you**, on board a regularly scheduled commercial airline or cruise line, upon which **you** were a fare-paying passenger; and
2. **You** must file a formal claim for lost luggage with the transportation provider, and follow all instructions and take all measures as directed by the transportation provider to locate and retrieve the lost checked luggage; and
3. **You** must provide **us** with copies of all documentation of the claim filed with the transportation provider, and a written statement from the transportation provider confirming that the luggage was checked and after careful search, the luggage remains missing; and
4. The lost checked luggage must be lost as of the date of **our** payment and as of that date, must have been lost for at least 10 days.

### **YOU ARE NOT COVERED IF:**

1. Expenses arise directly or indirectly from anything in the General Exclusions.

## LOST OR STOLEN PASSPORT/TRAVEL VISA

### **YOU ARE COVERED:**

1. Reimbursement for reasonable cost in replacing **your** passport or travel visa.

### **YOU ARE NOT COVERED** unless **you** fulfill the following conditions:

1. **You** exercise reasonable care for the safety and supervision of the passport or travel visa; and
2. Loss or theft is reported to the police within 24 hours and a written police report is obtained; and
3. **You** provide receipts for the costs associated with the passport or travel visa replacement.

### **YOU ARE NOT COVERED IF:**

1. Expenses arise directly or indirectly from anything in the General Exclusions.

## NATURAL DISASTER - REPLACEMENT ACCOMMODATIONS

### **YOU ARE COVERED:**

1. Replacement accommodations in the event **you** are **displaced** from planned paid accommodations due to evacuation from forecasted **natural disaster** or following a **natural disaster** strike.

### **YOU ARE NOT COVERED** unless **you** fulfill the following conditions:

1. Following receipt of proof of payment for the accommodations from which **you** were **displaced**.

### **YOU ARE NOT COVERED IF:**

1. Expenses arise directly or indirectly from anything in the General Exclusions.

**Displaced** means required to depart a destination due to an evacuation ordered by prevailing authorities.

**Natural Disaster** means an event of natural cause, including wildfire, earthquake, windborne dust or sand, volcanic eruption, tsunami, snow, rain or wind, that results in widespread and severe damage.

**Natural disaster** does not include the direct or indirect effect of rain, wind or water associated with named storms meeting the definition of hurricane or typhoon, except in instances where:

1. The path of the named storm deviates by a distance of greater than 200 miles within a 72-hour period from the path forecast by a nationally recognized meteorological service; or
2. Less than 72 hours advance notice of a potential landfall for a named storm exists.

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## ACCIDENTAL DEATH AND DISMEMBERMENT

### YOU ARE COVERED:

1. Death – **we** will pay the amount indicated in the Schedule of Benefits to the **beneficiary**; or
2. Loss of 2 or more limbs or eyes – **we** will pay **you** the amount indicated in the Schedule of Benefits; or
3. Loss of 1 limb or eye – **we** will pay **you** the amount indicated in the Schedule of Benefits.

### YOU ARE NOT COVERED unless **you** fulfill the following conditions:

1. The **accident** giving rise to the Accidental Death or Dismemberment must be covered under this insurance; and
2. Death must occur within 30 days of the sudden, unintentional and unexpected occurrence and not be contributed to by **illness** or disease.

### YOU ARE NOT COVERED IF:

1. Accidents or loss caused by or contributed to by any of the following:
  - a. Terrorism, war or act of war, whether declared or undeclared;
  - b. **Your** participation in a riot, insurrection or violent disorder;
  - c. **Your** service in the armed forces of any country;
  - d. Suicide or attempted suicide or self-inflicted **injury**, while sane or insane;
  - e. The voluntary use of any chemical compound, poison or drug, unless used according to the directions of a **physician**;
  - f. Committing or attempting to commit a felony;
  - g. Sickness, **mental health disorder**, or pregnancy;
  - h. As the result of intoxication as defined by the laws of the jurisdiction in which the **accident** occurred, whether directly or indirectly;
  - i. Myocardial infarction or cerebrovascular accident (CVA / Stroke);
  - j. Infection, except infection through a wound caused solely by an **accident**;
  - k. **Injury** while riding, boarding, or alighting from an aircraft if **you** were operating the aircraft, learning to operate the aircraft, serving as a member of the aircraft crew, or if the aircraft was being used for any purpose other than passenger transportation;
  - l. Medical or surgical treatment for any of the above; or
  - m. Any non-covered sports activities.
2. Expenses arise directly or indirectly from anything in the General Exclusions.

In no event will **our** payment under this benefit total more than the principal sum. The maximum liability under Accidental Death and Dismemberment for any group or family is limited to \$250,000.

**Accidental Death** means a sudden, unintentional and unexpected occurrence caused solely by external, visible means resulting in physical **injury** to **you** and **your** subsequent death. Death must occur within 30 days of the sudden, unintentional and unexpected occurrence and not be contributed to by **illness** or disease.

**Accidental Dismemberment** means a sudden, unintentional and unexpected occurrence caused solely by external, visible means and resulting in complete severance from the body of one or more limbs or eyes and not contributed to by illness or disease. For purposes of the Accidental Death and Dismemberment benefit, the term “limb” shall mean: the arm when the severance is at or above (toward the elbow) the wrist, or the leg when the severance is at or above (toward the knee) the ankle. Loss of eye(s) shall mean: complete, permanent, irrevocable loss of sight.

**Beneficiary** means the individual named in **your** application to be the recipient of any Accidental Death benefit. If **you** do not designate a **beneficiary** on the application, the **beneficiary** is automatically as follows:

**Members** age 18 or older: 1. Spouse (if any), 2. Children (if any) equally, 3. **Your** estate.

**Members** under age 18: 1. Custodial Parent(s) (if any), 2. Siblings (if any) equally, 3. **Your** estate

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# SPORTS AND ACTIVITIES

## YOU ARE COVERED:

1. **You** are covered for taking part in amateur/non-professional sports and activities, unless it is excluded below. Coverage is for recreational purposes incidental to a trip.

## YOU ARE NOT COVERED unless **you** fulfill the following conditions:

1. **You** must ensure the activity is adequately supervised and that appropriate safety equipment (such as protective headwear, life jackets etc.) are worn at all times.

## YOU ARE NOT COVERED IF:

1. The activity is organized athletics involving regular or scheduled practice and/or games; or
  2. The activity is performed in a professional capacity or for any wage, reward, or profit; or
  3. Expenses arise directly or indirectly from anything in the General Exclusions; or
  4. Any of the excluded items listed below:
    - All-Terrain Vehicles
    - American Football
    - Aussie Rules Football
    - Aviation (except when traveling solely as a passenger in a commercial aircraft)
    - Base Jumping
    - Big Game Hunting or Safari
    - Bobsleigh
    - Boxing
    - Bungee-Jumping
    - Cave Diving
    - Hang-Gliding
    - Heli-Skiing
    - Hot Air Ballooning as a Pilot
    - Ice Hockey
    - Jousting
    - Kite-Surfing
    - Luge
    - Martial Arts
    - Modern Pentathlon
    - Motorized Dirt Bikes
    - Mountaineering
    - Outdoor Endurance Events
    - Parachuting
    - Paragliding
    - Powerlifting
    - Quad Biking
    - Racing by any Animal, Motorized Vehicle, or BMX, and Speed Trials and Speedway
    - Rugby
    - Running with the Bulls
    - Skeleton
    - Sky Surfing
    - Snow Skiing and Snowboarding
    - Snow Mobiles
    - Spelunking
    - Sub Aqua Pursuits involving underwater breathing apparatus
    - Surfing
    - Tractors
    - Waterskiing
    - Whitewater Rafting
    - Wrestling
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# PERSONAL LIABILITY

## YOU ARE COVERED:

Up to the sum insured shown in the Schedule of Benefits and Limits (inclusive of legal costs and expenses) if **you** become legally liable to pay damages in respect of:

1. Accidental bodily **injury**, including death, **illness** and disease to a **third person**; and/or
2. Accidental loss of or damage to a **third person's** material property (property that is both material and tangible); and/or
3. Accidental loss of or damage to a **related third person's** material property (property that is both material and tangible).

## YOU ARE NOT COVERED unless **you** fulfill the following conditions:

1. **You** or **your** legal representatives will give **us** written notice immediately if **you** have received notice of any prosecution or inquest in connection with any circumstances which may give rise to liability under this section.
2. No admission, offer, promise, payment or indemnity shall be made by or on behalf of **you** without **our** prior written consent.
3. Every claim notice, letter, writ or process or other document served on **you** shall be forwarded to **us** and immediately upon receipt.
4. **We** shall be entitled to take over and conduct in **your** name the defense or settlement of any claim or to prosecute in **your** name for **our** own benefit any claim for indemnity or damages against all other parties or persons.
5. **We** may at any time pay **you** in connection with any claim or series of claims the sum insured (after deduction of any sums already paid as compensation) or any lesser amount for which such claim(s) can be settled. Once this payment is made **we** shall relinquish the conduct and control and be under no further liability in connection with such claim(s) except for the payment of costs and expenses recoverable or incurred prior to the date of such payment.
6. **We** will consider paying or advancing, but without any obligation or contractual duty to do so, up to \$2,500 to **you** or for **your** benefit to settle and compromise an asserted claim against **you** so long as:
  - a. The asserted claim is one that may be eligible for coverage under this insurance;
  - b. A lawsuit has not yet been filed, or, if already filed, no response has been filed;
  - c. **You** obtain a full written release and/or covenant-not-to-sue satisfactory to **us**; and
  - d. A full **proof of claim** and other necessary documentation is satisfactorily provided to **us**.

## YOU ARE NOT COVERED FOR:

1. Intentionally committed acts, or arising from the influence of alcohol or drugs not medically prescribed by a licensed **physician**;
2. Bodily **injury**, **illness** or disease of any person under a contract of employment, service or apprenticeship with **you** when the bodily **injury**, **illness** or disease arises out of and in the course of their employment to **you**, or in connection with any trade, business or profession;
3. Loss or damage to property belonging to or held in trust by or in the custody or control of **you** other than temporary accommodation occupied by **you** in the course of the trip;
4. Bodily **injury** or damage caused directly or indirectly in connection with the ownership, possession or use by **you** or on behalf of **you** of: aircraft, hovercraft, watercraft, motorized vehicles, parachute, parasail, glider, firearms, fireworks, explosives, deadly weapons, or any racing activity;
5. Any damages, losses or claims caused in whole or in part by **you** during any hunt or as a result of hunting;
6. Bodily **injury** caused directly or indirectly in connection with the ownership, possession or occupation of land or buildings, immobile property or caravans or trailers;
7. Damages resulting from any fire, flood, wind, hail, waterleak, gas leak, explosion or other catastrophe;

8. Fraudulent, dishonest or criminal acts of **you** or any person authorised by **you**;
9. The consequences of any breach, violation or failure to perform any contractual undertakings or obligations, whether verbal or in writing;
10. Punitive or exemplary damages, or fines, penalties, assessments or claims by any governmental authorities or regulatory bodies;
11. Gambling, gaming, or betting of any kind;
12. Animals or pets belonging to **you**, or in **your** care, custody or control;
13. Expenses arise directly or indirectly from anything in the General Exclusions.

**Third Person** means any individual, natural person, or other legal entity or person, other than **you** or a related third person.

**Related Third Person** means **your** relative, **your** traveling companion, **your** traveling companion's relative, and any other person, individual or family member with whom **you** are residing or being hosted.

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## TERRORISM

### YOU ARE COVERED:

1. Eligible Medical Expenses for treatment of **injuries** and **illnesses** resulting from an Act of Terrorism, up to the limit set forth in the Schedule of Benefits and Limits, provided all of the following conditions are met.

**YOU ARE NOT COVERED** unless **you** fulfill the following conditions:

1. The **injury** or **illness** does not result from the use of any biological, chemical, **cyber**, radioactive or nuclear agent, material, device or weapon;
2. **You** have no direct or indirect involvement in the Act of Terrorism;
3. The Act of Terrorism is not in a country or location where U.S. Department of State has issued a level 3 or level 4 travel advisory that has been in effect within the 6 months immediately prior to **your** date of arrival; and
4. **You** have not failed to depart a country or location within 10 days following the date a level 3 or level 4 travel advisory for that country or location is issued by the United States government.

### YOU ARE NOT COVERED IF:

1. Loss, damage, cost or expense directly or indirectly caused by, resulting from or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss, damage, cost or expense:
  - a. War, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power;
  - b. The use of any biological, chemical, **cyber**, radioactive or nuclear agent, material, device or weapon; however, this exclusion shall not apply where **you** are exposed to nuclear radioactive and/or radioactive material for the purpose of medical treatment;
  - c. Any Act of Terrorism, not specifically covered above;
  - d. Coverage for loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to (a), (b) or (c) above; or
  - e. Expenses arise directly or indirectly from anything in the General Exclusions.

For the purpose of this insurance, an "Act of Terrorism" means an act, including but not limited to, the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s) committed for political,

religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

If **we** allege that by reason of this exclusion, any loss, damage, cost or expense is not covered by this insurance, the burden of proving the contrary shall be upon **you**.

In the event any portion of this exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

**Cyber** means the use or operations, as a means for inflicting harm, of any computer, computer software program, malicious code, computer virus or process or any other electronic system.

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## GENERAL EXCLUSIONS

### Excluded Conditions, Treatments (includes Diagnoses, Tests, and Examinations), Services, Supplies, Acts, Omissions, and/or Events:

1. **Pre-existing Conditions**, except charges resulting directly from an Acute Onset of Pre-existing Condition, as herein defined, subject to the limits set forth in the Schedule of Benefits and Limits.
2. Birth defects and congenital illnesses. Birth defects are deemed to include hereditary conditions.
3. Pregnancy except as covered under Complications of Pregnancy, as herein defined, termination of pregnancy except in connection with covered Complications of Pregnancy, all charges related to pregnancy after the 26<sup>th</sup> week of pregnancy, routine prenatal care, child birth, postnatal care, and charges incurred by a child under the age of 14 days.
4. Impotency or sexual dysfunction.
5. All **sexually transmitted diseases** and conditions.
6. HIV, AIDS, or ARC, and all diseases caused by and/or related to HIV.
7. All forms of cancer / neoplasm.
8. **Substance abuse** or addiction or conditions that may be attributed to **substance abuse** or addictions and direct consequences thereof.
9. Acne, moles, skin tags, diseases of sebaceous glands, seborrhea, sebaceous cyst, hypertrophic and atrophic conditions of skin, nevus.
10. Sleep apnea or other sleep disorders.
11. Obesity or weight modification, including but not limited to wiring of the teeth and all forms of intestinal bypass **surgery**.
12. Self-inflicted **injury** or **illness** and/or suicide or attempted suicide whether sane or insane.
13. **Injury** sustained that is due wholly or partially to the effects of intoxication or drugs other than drugs taken in accordance with treatment prescribed by a **physician** and except drugs prescribed for the treatment of substance abuse.
14. **Injury** sustained while operating any motorized vehicle, aircraft or watercraft whether registered or not while under the influence of alcohol as defined under the law of the jurisdiction where the **injury** occurs or with a .08 Blood Alcohol Content (BAC), whichever is lower.
15. Routine medical examinations, including but not limited to vaccinations, immunizations, annual check-ups, the issue of medical certificates and attestations, and examinations as to the suitability of employment or travel.
16. Dental treatment and treatment of the temporomandibular joint, except for emergency dental treatment necessary to replace sound natural teeth lost or damaged in an **accident** covered hereunder or for the emergency relief of **acute onset of pain**.
17. Promotion or prevention of conception including but not limited to: artificial insemination, treatment for infertility, sterilization or reversal of sterilization.
18. Organ or tissue transplants or related services.



19. Eye **surgery**, such as corrective refractory **surgery**, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
20. Corrective devices and medical appliances, including eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, and any examination or fitting related to these devices, dentures or dental appliances, and all vision and hearing tests and examinations.
21. Orthoptics and visual eye training.
22. Orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses or toenails.
23. Hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed.
24. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinesiotherapy.
25. Psychometric, intelligence, competency, behavioral and educational testing.
26. Cosmetic or aesthetic reasons, except for reconstructive **surgery** when such **surgery** is directly related to and follows a **surgery** which was covered hereunder.
27. Modifications of the physical body intended to improve the psychological, mental or emotional well-being, including but not limited to sex-change **surgery**.
28. Exercise programs, whether or not prescribed or recommended by a **physician**.
29. Incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
30. Cryo preservation and implantation or re-implantation of living cells.
31. Genetic or predictive testing.
32. **Investigational, experimental or for research** purposes.
33. While confined primarily to receive **custodial care, educational or rehabilitative care**, or any medical treatment in any establishment for the care of the aged, except rehabilitative care received upon direct transfer from an acute care **hospital**.
34. Not **medically necessary**.
35. Not administered by or under the supervision of a **physician**, and products that can be purchased without a doctor's prescription.
36. Provided by a **relative**, family member or any person who ordinarily resides with **you**.
37. Provided at no cost to **you**.
38. Telephone consultations or failure to keep a scheduled appointment.
39. Payable under any government system, including the Australian Medicare system.
40. Charges exceeding **usual, reasonable and customary**.
41. Charges resulting from or occurring during the commission of a violation of law, including without limitation, the engaging in an illegal occupation or act, but excluding minor traffic violations.
42. Charges resulting from a disease outbreak in a country or location for which the U.S. Centers for Disease Control and Prevention (CDC) has issued a Level 3 Travel Warning if a) the warning has been in effect within the 6 months immediately prior to **your** date of arrival, or b) within 10 days following the date the warning is issued **you** have failed to depart the country or location.
43. War, military action or while on duty as a member of a police or military force unit.
44. Travel or accommodations, except as provided for in the Local Ambulance, Emergency Medical Evacuation, Repatriation of Remains, Emergency Reunion, Natural Disaster, Return of Minor Children, Political Evacuation, and Trip Interruption sections of this insurance.
45. Incurred outside **your certificate period**.
46. Submitted to **us** for payment more than 60 days after the last day of the **certificate period**.
47. When departure from the **home country** is to obtain treatment in the destination country/countries.
48. Complications or consequences of a treatment or condition not covered hereunder.
49. Not included as Eligible Expenses as described herein.

## DEFINITIONS

**Accident** means a sudden, unintentional and unexpected occurrence caused by external, visible means and resulting in physical **injury to you**. The cause or one of the causes of such **accident** is external to **your** own body and occurs beyond **your** control.

**Accidental Death** means a sudden, unintentional and unexpected occurrence caused solely by external, visible means resulting in physical **injury to you** and **your** subsequent death. Death must occur within 30 days of the sudden, unintentional and unexpected occurrence and not be contributed to by **illness** or disease.

**Accidental Dismemberment** means a sudden, unintentional and unexpected occurrence caused solely by external, visible means and resulting in complete severance from the body of one or more limbs or eyes and not contributed to by illness or disease. For purposes of the Accidental Death and Dismemberment benefit, the term "limb" shall mean: the arm when the severance is at or above (toward the elbow) the wrist, or the leg when the severance is at or above (toward the knee) the ankle. Loss of eye(s) shall mean: complete, permanent, irrevocable loss of sight.

**Acute Onset of Pain** (Emergency Dental) means a sudden and unexpected occurrence of pain which occurs spontaneously and without advance warning, either in the form of **physician** or dentist recommendation or symptoms, including pain, which would have caused a prudent person to seek medical or dental attention prior to the onset of pain. Treatment must be obtained within 24 hours of the sudden and unexpected occurrence of pain.

**Acute Onset of Pre-existing Condition** means a sudden and unexpected outbreak or recurrence of a **pre-existing condition(s)** which 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 care. The Acute Onset of a Pre-existing Condition(s) must occur after the certificate effective date. Treatment must be obtained within 24 hours of the sudden and unexpected outbreak or recurrence. A **pre-existing condition** that is a chronic or congenital condition or that gradually becomes worse over time will not be considered Acute Onset. This benefit does not include coverage for known, scheduled, required, or expected medical care, drugs or treatments existent or necessary prior to the certificate effective date.

**Beneficiary** means the individual named in **your** application to be the recipient of any Accidental Death benefit. If **you** do not designate a **beneficiary** on the application, the **beneficiary** is automatically as follows:

**Members** age 18 or older: 1. Spouse (if any), 2. Children (if any) equally, 3. **Your** estate.

**Members** under age 18: 1. Custodial Parent(s) (if any), 2. Siblings (if any) equally, 3. **Your** estate.

**Certificate** means the document issued to **you** that provides evidence of benefits payable under the Master Policy and that will confirm the plan type, period of cover, **home country**, certificate number, special terms and/or conditions, **deductible**, chosen benefit list, and geographical area of cover.

**Certificate Period** means the period of time beginning on the date and time of the **certificate effective date** and ending on the date and time of the **certificate termination date**. The maximum certificate period is 364 days.

**Coinsurance** means **your** payment of eligible expenses at the percentage specified in the Schedule of Benefits and Limits.

**Complications of Pregnancy** means **illnesses** whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or caused by pregnancy and not associated with a normal pregnancy. This includes: ectopic pregnancy, spontaneous abortion, hyperemesis gravidarum, pre-eclampsia, eclampsia, missed abortion and conditions of comparable severity. Complications of Pregnancy does not include: false labor, edema, prolonged labor, prescribed rest during the period of pregnancy, morning sickness and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically distinct condition.

**Custodial Care** means that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist **you** in performing the activities of daily living. Custodial care also includes non-acute care for the comatose, semi-comatose, paralyzed or mentally incompetent patients.

**Cyber** means the use or operations, as a means for inflicting harm, of any computer, computer software program, malicious code, computer virus or process or any other electronic system.

**Deductible** means the dollar amount of eligible expenses, specified in the Schedule of Benefits and Limits that **you** must pay per **certificate period** before eligible expenses are paid.

**Displaced** means required to depart a destination due to an evacuation ordered by prevailing authorities.

**Durable Medical Equipment** means a standard basic hospital bed and/or a standard basic wheelchair.

**Educational or Rehabilitative Care** means care for restoration (by education or training) of one's ability to function in a normal or near normal manner following an **illness** or **injury**. This type of care includes, but is not limited to, vocational or occupational therapy and speech therapy.

**Emergency** means 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.

**Extended Care Facility** means an institution, or a distinct part of an institution, which is licensed as a **hospital, extended care facility** or rehabilitation facility by the state in which it operates; and is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a **physician** and the direct supervision of a registered nurse; and maintains a daily record on each patient; and provides each patient with a planned program of observation prescribed by a **physician**; and provides each patient with active treatment of an **illness** or **injury**. **Extended care facility** does not include a facility primarily for rest, the aged, **substance abuse** treatment, **custodial care**, nursing care or for care of **mental health disorders** or the mentally incompetent.

**Home Country** means the country where **you** principally reside and receive regular mail.

**Home Health Care Agency** means a public or private agency or one of its subdivisions, which operates pursuant to law and is regularly engaged in providing home nursing care under the supervision of a registered nurse, and maintains a daily record on each patient, and provides each patient with a planned program of observation and treatment by a **physician**.

**Home Nursing Care** means services provided by a **home health care** agency and supervised by a registered nurse, which are directed toward the personal care of a patient, provided always that such care is provided in lieu of **medically necessary inpatient** care in a **hospital**.

**Hospital** means an institution which operates as a **hospital** pursuant to law, and is licensed by the state or country in which it operates; and operates primarily for the reception, care and treatment of sick or injured persons as **inpatients**; and provides 24-hour nursing service by registered nurses on duty or call; and has a staff of one or more **physicians** available at all times; and provides organized facilities and equipment for diagnosis and treatment of acute medical conditions on its premises; and is not primarily a rehabilitation facility, long-term care facility, **extended care facility**, nursing, rest, **custodial care** or convalescent home, a place for the aged, drug addicts, alcoholics or runaways; or similar establishment.

**Illness** means a sickness, disorder, **illness**, pathology, abnormality, ailment, disease or any other medical, physical or health condition. For purposes of this insurance, **illness** includes Complications of Pregnancy during the first 26 weeks of pregnancy. **Illness** does not include learning disabilities, attitudinal disorders or disciplinary problems.

**Injury** means an unexpected and unforeseen harm to the body caused by an accident that requires medical treatment.

**Inpatient** means a patient who occupies a hospital bed for more than 24 hours for medical treatment and whose admission was recommended by a **physician**, or a patient held for observation in a hospital for at least 12 hours.

**Intensive Care Unit** means a cardiac care unit or other unit or area of a **hospital** that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

**Investigational, Experimental or for Research Purposes** means procedures, services or supplies that are by nature or composition, or are used or applied, in a way which deviates from generally accepted standards of current medical practice.

**Medically Necessary** means a service or supply which is necessary and appropriate for the diagnosis or treatment of an **illness** or **injury** based on generally accepted current medical practice as determined by **us**. A service or supply will not be considered **medically necessary** if is provided only as a convenience to **you** or the provider, and/or is not appropriate for **your** diagnosis or symptoms, and/or exceeds in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment of an **illness** or **injury**.

**Member** means an individual who is covered under this insurance.

**Mental Health Disorder** means a mental or emotional disease or disorder which generally denotes a disease of the brain with predominant behavioral symptoms; or a disease of the mind or personality, evidenced by abnormal behavior; or a disorder of conduct evidenced by socially deviant behavior. Mental health disorders include: psychosis, depression, schizophrenia, bipolar affective disorder, and those psychiatric illnesses listed in the current edition of the diagnostic and Statistical Manual for Mental Disorders of the American Psychiatric Association.

**Natural Disaster** means an event of natural cause, including wildfire, earthquake, windborne dust or sand, volcanic eruption, tsunami, snow, rain or wind, that results in widespread and severe damage.

**Natural disaster** does not include the direct or indirect effect of rain, wind or water associated with named storms meeting the definition of hurricane or typhoon, except in instances where:

1. The path of the named storm deviates by a distance of greater than 200 miles within a 72-hour period from the path forecast by a nationally recognized meteorological service
2. Or less than 72 hours advance notice of a potential landfall for a named storm exists.

**Outpatient** means a **member** who receives **medically necessary** treatment by a **physician** for **injury** or **illness** that does not require overnight stay in a **hospital**.

**Physician** means a Doctor of Medicine (MD), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DDM), Doctor of Podiatry (DPM), Doctor of Osteopathy (DO), Doctor of Chiropractic, a licensed Physical Therapist or Physiotherapist, and a Doctor of Psychiatry (Psy.D) and a Doctor of Psychology (Ph.D.). Physician also includes a Certified Nurse Practitioner (CNP), Certified Registered Nurse Anesthetist (CRNA), Nurse Midwife or a Physician Assistant (PA) under the direction of a medical doctor. A physician must be currently licensed by the jurisdiction in which the services are provided, and the services must be within the scope of that license and covered under this Master Policy.

**Related Third Person** means **your** relative, **your** traveling companion, **your** traveling companion's relative, and any other person, individual or family member with whom **you** are residing or being hosted.

**Relative** means biological or step parent; biological or step child; current spouse; biological or stepsiblings; or parent, children, or sibling in law.

**Routine Physical Exam** means an examination of the physical body by a **physician** for preventative or informative purposes only, and not for the diagnosis or treatment of any condition.

**Sexually Transmitted Diseases** means diseases including but not limited to syphilis, gonorrhea, chlamydiosis, trichomoniasis, genital herpes, and Human Papillomavirus (HPV).

**Substance Abuse** means alcohol, drug or chemical abuse, overuse or dependency.

**Surgery or Surgical Procedure** means 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.

**Third Person** means any individual, natural person, or other legal entity or person, other than **you** or a related third person.

**Urgent Care Center** means a U.S. medical facility separate from a **hospital** emergency department where ambulatory patients can be treated on a walk-in basis without an appointment and receive immediate, non-routine urgent care for an **injury** or **illness** presented on an episodic basis.

**Usual, Reasonable and Customary** means the lesser of the following:

1. One and a half times (150%) of the charges payable under the United States Medicare program, for claims incurred outside the PPO network within the U.S., or
2. Most common charge for similar services, medicines or supplies within the area in which the charge is incurred, so long as those charges are reasonable. What is defined as **usual, reasonable and customary** charges will be determined by **us**. In determining whether a charge is **usual, reasonable and customary**, **we** may consider one or more of the following factors: the level of skill, extent of training, and experience required to perform the procedure or service; the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services; the severity or nature of the **illness** or **injury** being treated; the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country; the cost to the provider of providing the service, medicine or supply; such other factors **we**, in the reasonable exercise of discretion, determine are appropriate.

**You/Your** means each insured person named in the **certificate**.

**We/Us/Our** means Tokio Marine HCC - Medical Insurance Services Group.

## OPTIONAL ENHANCED ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT RIDER

Subject to the Limits set in the Schedule of Benefits and subject to the conditions and restrictions contained in this policy, **we** will pay the following Optional Enhanced Accidental Death and Dismemberment benefit if elected by **you** and subject to the payment of premium and restrictions outlined below.

Optional Accidental Death is defined as: A sudden, unintentional and unexpected occurrence caused solely by external, visible means resulting in **your** physical injury and subsequent death. Death must occur within 30 days of the sudden, unintentional and unexpected occurrence and not be contributed to by **illness** or disease.

Optional Accidental Dismemberment is defined as: A sudden, unintentional and unexpected occurrence caused solely by external, visible means and resulting in complete severance from the body of one or more limbs or eyes and not contributed to by **illness** or disease. For purposes of the Accidental Death and Dismemberment benefit provided by this insurance, the term "limb" shall mean: the arm when the severance is at or above (toward the elbow) the wrist, or the leg when the severance is at or above (toward the knee) the ankle. Loss of eye(s) shall mean: complete, permanent, irrevocable loss of sight.

### YOU ARE COVERED:

1. Death – **we** will pay the amount indicated in the Schedule of Benefits to the **beneficiary**.
2. Loss of 2 or more limbs or eyes – **we** will pay **you** the amount indicated in the Schedule of Benefits.
3. Loss of 1 limb or eye – **we** will pay **you** the amount indicated in the Schedule of Benefits.

**YOU ARE NOT COVERED** unless **you** fulfill the following conditions:

1. **You** must be younger than age 70; and
2. The **accident** giving rise to the Optional Accidental Death or Dismemberment must be covered under this insurance; and
3. Death must occur within 30 days of the sudden, unintentional and unexpected occurrence and not be contributed to by **illness** or disease.

### YOU ARE NOT COVERED IF:

1. Accidents or loss caused by or contributed to by any of the following:
  - a. Terrorism, war or act of war, whether declared or undeclared.
  - b. **Your** participation in a riot, insurrection or violent disorder.
  - c. **Your** service in the armed forces of any country.
  - d. Suicide or attempted suicide or self-inflicted **injury**, while sane or insane.
  - e. The voluntary use of any chemical compound, poison or drug, unless used according to the directions of a **physician**.
  - f. Committing or attempting to commit a felony.
  - g. Sickness, **mental health disorder**, or pregnancy.
  - h. As the result of intoxication as defined by the laws of the jurisdiction in which the **accident** occurred, whether directly or indirectly,
  - i. Myocardial infarction or cerebrovascular accident (CVA / Stroke).
  - j. Infection, except infection through a wound caused solely by an **accident**.
  - k. **Injury** while riding, boarding, or alighting from an aircraft if **you** were operating the aircraft, learning to operate the aircraft, serving as a member of the aircraft crew, or if the aircraft was being used for any purpose other than passenger transportation.

- l. Medical or surgical treatment for any of the above.
  - m. Any non-covered sports activities.
- 2. Expenses arise directly or indirectly from anything in the General Exclusions.

In no event will **our** payment under this benefit total more than the principal sum.  
All other provisions of the Master Policy remain unchanged.



## OPTIONAL HAZARDOUS ACTIVITIES RIDER

Subject to the Limits set forth in the Schedule of Benefits and subject to the conditions and restrictions contained in this policy, the Sports and Activities Eligible Expense will be deleted in its entirety and replaced with the following Optional Hazardous Activities Rider, if elected by **you** and subject to the payment of premium and restrictions outlined below.

### **YOU ARE COVERED:**

1. **You** are covered for taking part in amateur/non-professional sports and activities, unless it is excluded below. Coverage is for recreational purposes incidental to a trip.

### **YOU ARE NOT COVERED** unless **you** fulfill the following conditions:

1. **You** must ensure the activity is adequately supervised and that appropriate safety equipment (such as protective headwear, life jackets etc.) are worn at all times.

### **YOU ARE NOT COVERED IF:**

1. The activity is organized athletics involving regular or scheduled practice and/or games; or
2. The activity is performed in a professional capacity or for any wage, reward, or profit; or
3. Expenses arise directly or indirectly from anything in the General Exclusions; or
4. Any of the excluded items listed below:

- All-Terrain Vehicles
- Aussie Rules Football
- Aviation (except when traveling solely as a passenger in a commercial aircraft)
- Base Jumping
- Bobsleigh
- Boxing
- Cave Diving
- Heli-Skiing
- Hot Air Ballooning as a Pilot
- Ice Hockey
- Jousting
- Luge
- Martial Arts
- Modern Pentathlon
- Motorized Dirt Bikes
- Mountaineering at elevations of 4,500 meters or higher
- Outdoor Endurance Events
- Quad Biking
- Racing by any Animal, Motorized Vehicle, or BMX, and Speed Trials and Speedway
- Rugby
- Skeleton
- Snow Skiing and Snowboarding, except recreational downhill and/or cross country snow skiing or snowboarding (no cover provided while skiing away from prepared and marked in-bound territories and/or against the advice of the local ski school or local authoritative body)
- Sub Aqua Pursuits involving underwater breathing apparatus unless accompanied by a certified instructor at depths less than 10 meters, or PADI/NAUI certified
- Tractors
- Wrestling

All other provisions of the Master Policy remain unchanged.

## OPTIONAL INTERCOLLEGIATE / INTERSCHOLASTIC SPORTS RIDER

Subject to the Limits set in the Schedule of Benefits and subject to the conditions and restrictions contained in this policy, **we** will pay the following Optional Intercollegiate/Interscholastic Sports Rider benefit if elected by **you** and subject to the payment of premium and restrictions outlined below.

### **YOU ARE COVERED:**

1. New injury or illness sustained while covered under this policy and taking part in the following sports or other athletic activities that are organized and/or sanctioned, involving regular or scheduled practices and/or regular or scheduled games:

- Baseball
- Cheerleading
- Cross Country
- Cycling
- Diving
- Equestrian
- Field Hockey
- Golf
- Gymnastics
- Ice Hockey
- Martial Arts
- Polo Horse
- Rugby
- Skiing
- Soccer
- Softball
- Swimming
- Tennis
- Track & Field
- Volleyball
- Water Polo
- Wrestling

### **YOU ARE NOT COVERED IF:**

1. The activity is performed in a professional capacity or for any wage, reward, or profit; or
2. The injury or illness is sustained while **you** are not actively covered hereunder; or
3. Expenses arise directly or indirectly from anything in the General Exclusions.

All other provisions of the Master Policy remain unchanged.