SIRIUSPOINT AMERICA INSURANCE COMPANY

ONE WORLD TRADE CENTER
285 FULTON STREET, 47TH FLOOR
NEW YORK, NY 10007

MASTER POLICY
BLANKET HEALTH INSURANCE POLICY

Underwritten by: SiriusPoint America Insurance Company
One World Trade Center
285 Fulton Street, 47th Floor
New York, NY 10007

Administrator: ASRM, LLC
505 South Lenola Road, Suite 231
Moorestown, NJ 08057
800-359-7475

SiriusPoint America Insurance Company, referred to in this Policy as "We," "Us," "Our" or "the Company," issues this Master Policy to the Policyholder named in the Policy Schedule.

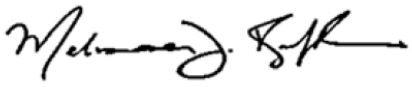
This Master Policy (hereafter referred to as Master Policy or Policy) is issued to the Policyholder named in the Policy Schedule. It takes effect on the effective date shown in the Policy Schedule.

In return for the payment of premium, We will pay the benefits which this Master Policy Provides for persons insured hereunder for certain losses, as specified in the DESCRIPTION OF BENEFITS, for loss due to Injury or Sickness that occurs while this Policy and the Covered Person's coverage are in force. The Master Policy is delivered in and is subject to the laws of the state in which it is issued.

We and the Policyholder have agreed to all of the terms of this Master Policy.

This is a legal contract between the Policyholder and Us.
READ THIS MASTER POLICY CAREFULLY.

Executed at New York, New York on the Issue Date.



Melissa J. Ralph
Secretary

Paul Mihulka
President

POLICY SCHEDULE

POLICYHOLDER: IEES Insurance Trust

SUBSCRIBER: Newman University

POLICY NUMBER: EXL-SA10038-25

POLICY EFFECTIVE DATE: August 1, 2025

POLICY TERM: The Policy will go into effect on the Policy Effective Date. All periods of insurance for a Covered Person begin and end at 12:01 A.M. Standard Time at the Policyholders address. The period beginning on the Policy Effective Date and ending at 12:01 A.M. on August 1, 2026.

PREMIUM DUE DATE: The Policy Effective Date and each succeeding interval

RENEWABILITY: Non-Renewable

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ELIGIBILITY

The Eligible Persons are:

Eligible Class	Description
1	A registered full time undergraduate or a graduate student attending classes who is a minimum age of 16 years and maximum of 64 years: 1. Student must have a current passport and be travelling outside their Home Country, and 2. Student must have a valid F1 visa. F1 visa holder on OPT are not eligible.
Or	A J1 valid visa holder who is outside their Home Country and is actively engaged in an educational activity and who is a minimum age of 16 years and a maximum age of 64 years, if you are one of the following: 1. Undergraduate student registered for and attending classes on a full-time basis; or 2. Graduate student; or 3. Scholar or researcher who is invited by an educational organization; or 4. Student involved in education, educational activities, or research related activities.
2	Spouse or domestic partner of Class 1
3	Dependent children of Class 1

Eligible Classes may be afforded the following Coverage:

Coverage Description	Eligible Classes
24-Hour Accident & Sickness Coverage	1, 2 & 3

PREMIUM SCHEDULE

Eligible Class(es)	Annual	Fall	Spring	Summer
Student/J1 Visa Holder (Class 1)	$960.00	$400.00	$400.00	$160.00
Spouse (Class 2)	$3,360.00	$1,400.00	$1,400.00	$560.00
Dependent Child (for each enrolled Child) (Class 3)	$1,920.00	$800.00	$800.00	$320.00

Coverage Dates

Annual	8/1/2025 – 7/31/2026
Fall	8/1/2025 – 12/31/2025
Spring	1/1/2026 – 5/31/2026
Summer	6/1/2026 – 7/31/2026

SCHEDULE OF BENEFITS

Eligible Class(es): 1, 2 & 3

Coverage Description: 24-Hour Accident & Sickness Coverage

Description of Benefits: Medical Expense Benefit - Injury & Sickness

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto. Benefits are payable on the following basis:

For Injury or Sickness: __X__ Primary

Deductible

Policy Term Deductible[1]:	$100 ($200 for family)

Coinsurance

Benefit Percentage the Policy Pays:	80% (after deductible, co-payments[2] and payment of 20% Coinsurance[3]), until the Covered Person has reached their out-of-pocket[4] maximum of $6,000 ($12,000 for family). Once the Covered Person has satisfied their out-of-pocket maximum, it will be 100%. 100% of covered expenses for preventive services. 100% of covered prescriptions after applicable co-payments up to the outpatient prescription drug maximum of $3,000 per Covered Person per year.

Co-payments[2]

Physician office per visit[5]	$20
Hospital Inpatient stay	$50
Emergency Room per visit[6]	$300
Outpatient Prescription Drugs	
Generic	$20 per prescription
Brand Name	$50 per prescription

[1] The Deductible does not apply to the Out-of-Pocket.

[2] Co-payments do not apply to the Deductible or Out-Of-Pocket.

[3] Coinsurance means the portion of Covered Expenses that the Covered Person must pay.

[4] The Out-of-Pocket expenses are the Coinsurance amounts that the Covered Person is responsible to pay. (Limitations and Exclusions are NOT included in calculating Out-of-Pocket.)

[5] Co-payment is waived at the campus health center.

[6] Emergency Room Co-payment is waived if Covered Person is immediately admitted to a Hospital.

Maximum Benefit for All Covered Expenses: $300,000 per Covered Person

Other Benefit Maximums:
Dental Treatment: Maximum of $2,500 per Covered Person
Intercollegiate, interscholastic, intramural or club sports Injury: Maximum of $10,000 per Covered Person
Pre-Existing Conditions for the first six months: Maximum of $1,000 per Covered Person
Outpatient Physiotherapy/Occupational Therapy/Speech Therapy is limited to 20 visits per Covered Person per Policy Term.

Limited Home Country Benefit:

Maximum Benefit Per Policy Term: $1,500

See details under the Medical Treatment Received in Home Country provision on page 10

DEFINITIONS

Accident means a sudden, unexpected and unintended incident. "Covered Accident" means an Accident that results in Injury or loss covered by this Policy.

Coinsurance means the portion of Covered Expenses that the Insured has to pay.

Co-payment means a specified charge that the Covered Person is required to pay when a medical service is rendered.

Covered Person means any Eligible Person and, where applicable, Eligible Dependents who makes application for, or for whom application is made and who is approved to participate in the benefit plans issued under this Policy, provided the required premium for such Person's and Dependents' insurance is paid when due.

Deductible means the amount of Covered Expenses the Insured owes before we begin to pay for Covered Expenses.

Hospital means a legally constituted institution having organized facilities for the care and Treatment of sick or injured persons on a registered Inpatient basis, including facilities for diagnosis and surgery under the supervision of a staff or one or more licensed Physicians and provides 24-hour nursing service by Registered Nurses on duty or call.

Injury means accidental bodily harm sustained by the Covered Person that resulted directly and independently of all other causes from an Accident and occurs while coverage under this Policy is in force.

Inpatient means confinement for which the Covered Person is charged at least one full day's room and board.

Insured means the student/program participant who is a Covered Person under the Policy**.**

Intensive Care Unit means a section, ward, or wing within a Hospital which is separated from other Hospital facilities and (1) is operated exclusively for the purpose of providing professional Treatment for critically ill patients; (2) has special supplies and equipment necessary for such Treatment which are available on a standby basis for immediate use; (3) provides room and board, and constant observation by registered graduate nurses or other specially trained Hospital personnel; and (4) is not maintained for the purpose of providing normal post-operative recovery Treatment or service.

Medical Emergency means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:

a) placing the patient's health in serious jeopardy; or

b) serious impairment to bodily functions; or

c) serious dysfunction of any bodily organ or part.

Medically Necessary or Medical Necessity means the services or supplies provided by a Hospital, Physician, or other provider that are required to identify or treat an Injury or Sickness and which, as determined by the Company, are: (1) consistent with the symptom or diagnosis and Treatment of the Injury or Sickness; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the Covered Person; (4) the most appropriate supply or level of service which can be safely provided. When applied to the care of an Inpatient, it further means that the Covered Person's medical symptoms or condition requires that the services cannot be safely provided as an Outpatient. The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Policy.

Nurse means a person who has been registered or licensed to practice by the State Board of Nurse Examiners or other state authority in the state where they work, and who is practicing within the scope and limitation of that license. The term Nurse will not include the Covered Person or their spouse, children, brothers, sisters, or parents, or any person residing in their household.

Orthotic Devices means rigid or semi-rigid devices supporting a weak or deformed leg, foot, arm, hand, back or neck or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck. Benefits for Orthotic Devices include orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. An Orthotic Device differs from a prosthetic in that, rather than replacing a body part, it supports and/or rehabilitates existing body parts. Orthotic Devices are usually customized for a Covered Person's use and are not appropriate for anyone else. Examples of Orthotic Devices include but are not limited to Ankle Foot Orthosis (AFO), Knee Ankle Foot Orthosis (KAFO), Lumbosacral Orthosis (LSO).

Outpatient Surgical Facility means a surgical or medical center, which has (1) permanent facilities for surgery; (2) organized medical staff of Physicians and registered graduate nurses; and (3) is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under that law.

Physician means a practitioner of the healing arts who is duly licensed in the state where they are practicing and who is treating within the scope and limitation of that license. The term Physician will not include the Covered Person or their spouse, children, brothers, sisters, or parents, or any person residing in their household.

Pre-existing Conditions means a condition for which a Covered Person received medical treatment, care or advice within 6 months before being insured under this Policy.

Prosthetic Devices (excluding dental) means artificial limb devices or appliances designed to replace in whole or in part an arm or a leg. Benefits for Prosthetic Devices include coverage of devices that replace all or part of a permanently inoperative or malfunctioning internal or external organ, and are furnished on a Physician's order. Examples of Prosthetic Devices include but are not limited to artificial limbs, cardiac pacemakers, prosthetic lenses, breast prosthesis (including mastectomy bras), hair prosthesis and maxillofacial devices.

Registered Nurse means a person who has received the designation of "Registered Nurse (R.N.)" and is registered and licensed to practice by the State Board of Nurse Examiners or other state authority in the state where they work, and who is practicing within the scope and limitation of that license. The term Registered Nurse will not include the Covered Person or their spouse, children, brothers, sisters, or parents, or any person residing in their household.

Sickness means illness or disease contracted and causing loss as to the Covered Person whose Sickness is the basis of claim. Any complications or any condition arising out of a Sickness for which the Covered Person is being treated or has received Treatment will be considered as part of the original Sickness.

Skilled Nursing Facility means a facility which is licensed pursuant to state and local laws; is operated primarily for the purpose of providing skilled nursing care and Treatment for individuals convalescing from Injury or Sickness including room and board and provides 24 hour a day skilled nursing services under the full time supervision of a Physician or Registered Nurse and if full time supervision by a Physician is not provided has , it has the services of a Physician available under a fixed agreement; it keeps adequate medical records and has organized facilities for medical Treatment. Skilled Nursing Facility does not include an institution or part of one that is used mainly as a place for rest or the aged.

Subscriber Any participating school or organization that is affiliated with the Policyholder and subscribes to the insurance plan provided by this Policy.

Treatment means a specific in-office or Hospital physical examination of, or care rendered to, the Covered Person.

Usual, Customary, and Reasonable Charges - "Usual" means those charges made by a provider for services and supplies rendered to all patients for the same or similar Injury or Sickness; "Customary" means

those charges made by the majority of providers in the area for the same or similar services or supplies. "Reasonable" means those charges that do not exceed the majority of prevailing fees in the area for the same or similar services or supplies. Area means a county or larger geographically significant area as determined by the Company.

INDIVIDUAL INSURING PROVISIONS

Subscriber Participation Under This Policy
A school or organization may elect to participate under this Policy by submitting a signed subscription and service agreement to the Policyholder. No participation by a school or organization is in effect until approved by Us.

Eligible Persons - The persons eligible for coverage are all persons denoted in the classifications described in the Eligibility Section.

Enrollment Period - Eligible Persons may enroll prior to departure to, or within 30 days of arrival in the country of assignment. Such participants are eligible for coverage under the Policy subject to the particular types and amounts of insurance as specified in the enrollment form.

When Coverage Begins - Any such Eligible Person will automatically become an Insured with respect to the coverage under this Policy at 12:01 A.M. on the latest of the following dates:

1. the effective date of this Policy; or

2. the effective date of the Subscriber's participation under this Policy; or

3. the date he or she comes within a classification of Eligible Persons, or

4. the date that a completed enrollment form (if any) and the required premium payment for their coverage is received by the Company.

When Coverage Ends - Coverage with respect to any Insured will end at 12:01 A.M. on the earliest of the following dates:

1. the date this Policy is terminated; or

2. the date the Subscriber with which the Covered Person is affiliated ceases to be a Subscriber under this Policy; or

3. the premium due date, if the required premium is not paid within 31 days following such premium due date; or

4. the date such Covered Person ceases to come within any classification of Eligible Persons; or

5. the Coverage Expiration Date contained in the COVERAGE DESCRIPTION.

In the event an Insured enters the armed forces, unearned premium will be returned, but the amount returned will only be for the number of full months of the unexpired term of coverage, less any administrative fees.

Coverage ending will not affect a claim for: a covered expense due to an Injury or Sickness provided such expense was incurred while coverage was in effect as to the Covered Person.

Dependent Coverage - An Insured for whom Accident and Sickness coverage is in force under this Policy may also make application to insure their Eligible Dependents.

Eligible Dependents: Eligible Dependents are the Covered Person's legal spouse or civil union partner and/or dependent children who are under age 26 who are not self-supporting and who reside with the Covered Person. This definition includes the dependent children of a civil union partner.

Enrollment Period: An Insured may enroll their Eligible Dependents on the date that the Insured enrolls for coverage, or within 31 days from the date that the Eligible Dependent arrives in the country of assignment. An Insured's legal spouse may be enrolled within 31 days of the date they were legally married. Newborn children must be enrolled within 31 days after their date of birth or placement for adoption.

When Coverage Begins: An Eligible Dependent's coverage will begin at 12:01 A.M. on the latest of the following dates:

1. the effective date of the Insured's coverage; or

2. the date the participation of the Subscriber with which the Insured is affiliated becomes effective; or

3. the date the dependent meets the eligibility requirements; or

4. the date that a completed enrollment form (if any) and the required premium payment for dependent coverage are received by the Company.

When Coverage Ends: Coverage with respect to any covered dependent will end at 12:01 A.M. on the earliest of the following dates:

1. the date the Insured is no longer covered under the Policy; or

2. the date the Subscriber with which the Covered Person is affiliated ceases to be a Subscriber under this Policy;

3. the premium due date, if the required premium for dependent coverage is not paid within 31 days following such premium due date; or

4. the date such dependent ceases to meet the dependent eligibility requirements.

However, coverage will continue for any child who reaches the age limit and is both:

a) totally incapable of self-sustaining employment due to a physical or mental handicap; and

b) chiefly dependent on the Insured for support and maintenance.

The Insured must give the Company proof of the child's incapacity and dependency within 31 days of the child reaching the age limit. The Company may require proof again from time to time but not more often than once a year after the 2 years that follow the child reaching the age limit.

Premium will be refunded in full or pro-rated if it is later determined that the dependent is not eligible for coverage or if the enrollment form and/or subsequent renewal forms (if any) contained inaccurate or misleading information.

Coverage ending will not affect a claim for: (1) a covered accidental death or dismemberment loss due to an Accident that occurred while coverage was in effect as to the Covered Person; and (2) a covered expense due to an Injury or Sickness provided such expense was incurred while coverage was in effect as to the Covered Person.

Coverage of a Newborn Child: A child of the Insured born while Sickness coverage under this Policy is in force as to the Covered Person will automatically be insured from the moment of birth until 31 days following the date of birth or placement for adoption. Such child will be insured, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and prematurity, subject to the particular Coverages and amounts of insurance as specified in the Schedule of Benefits.

In order to continue coverage for the newborn child beyond the first 31 days, the Insured must, within 31 days after the date of birth, provide written notice of the birth to the Company and pay the required premium (if any). If this is not done, coverage for the newborn child will end 31 days after the date of birth.

Domestic Partner Coverage: An Insured may elect coverage under the policy for his or her qualified domestic partner and children of a qualified domestic partner who would be eligible for coverage if they were the Insured's children. The coverage provided to such persons will be on the same basis as that provided to an Eligible Dependent of the Insured.

"Qualified domestic partner" means either:

a) if the state in which the policy is delivered does not recognize domestic partnerships, a person: who is at least 18 years of age; who is not related to the Insured by blood; who has been living together with the Insured for at least 12 consecutive months; who is financially interdependent with the Insured for all living expenses; and, for whom a written affidavit of domestic partnership, acceptable to us, has been completed; or

b) if the state in which the policy is issued recognizes domestic partnerships, a person who together with the Insured has filed and maintains a valid Declaration of Domestic Partnership with the applicable regulatory body in the state in which the policy is issued.

An Insured may not have more than one qualified domestic partner nor may a person be a qualified domestic partner for more than one person. The Insured must notify the Administrator within 30 days if there is any change in the domestic partner status between the Insured and qualified domestic partner. A signed statement of termination of domestic partnership will be required.

COVERAGE DESCRIPTIONS

Unless otherwise stated, we will pay benefits for a covered loss only once, even if coverage was provided under more than one Coverage Description.

24-HOUR ACCIDENT AND SICKNESS COVERAGE

Effective Term: This coverage will be in effect with respect to a Covered Person from the effective date of the policy, or as described in the applicable provision titled When Coverage Begins (in the section titled INDIVIDUAL INSURING PROVISIONS), whichever is later, and ending with the Coverage Expiration Date.

Coverage Expiration Date: The date described in the applicable provision titled When Coverage Ends in the section titled INDIVIDUAL INSURING PROVISIONS.

Description of Hazards: All Covered Expenses incurred as a result of the same or related cause (including any complications) shall be considered as resulting from one Injury or Sickness.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE BENEFIT –INJURY AND SICKNESS

When Benefits are Payable: The Company will pay benefits for those Covered Expenses incurred by the Covered Person in accordance with the COVERAGE DESCRIPTION.

Covered Expenses must be incurred during the Policy Term, and while the Covered Person remains continuously insured under this Policy. A Covered Expense will be deemed to have been incurred when the service or Treatment to which it relates is provided.

Amount of Benefits Payable: The amount of the benefit payable will be the eligible Covered Expenses incurred in excess of the Deductible Amount (if any) shown on the Schedule of Benefits, subject to:

1. any coinsurance amount applicable to such Covered Expense,
2. any Co-payment amount applicable to such Covered Expense; and

3. any maximum amount payable for a specific Covered Expense; and
4. any Maximum Benefit amount payable for all such Covered Expenses.

These amounts, if applicable, are as shown on the Schedule of Benefits.

Payment of this benefit is subject to all other terms and conditions of this Policy.

Covered Expenses: Covered Expenses will be limited to the Usual, Customary and Reasonable Charges incurred by the Covered Person for Medically Necessary care and Treatment. Covered Expenses include:

1. Room and Board Expense: a) daily semi-private room rate when confined in a Hospital as an Inpatient; and b) general nursing care provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge. Intensive Care Unit charges are limited to three times the semi-private room and board rate per day.

2. Hospital Miscellaneous Expenses: a) while confined in a Hospital as an Inpatient; or b) as a precondition for being confined in a Hospital as an Inpatient. Benefits will be paid for services and supplies such as: the cost of an operating room; laboratory tests; X-ray examinations (not treatment); anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies.

3. Inpatient Physiotherapy/Occupational Therapy/Speech Therapy.

4. Inpatient Surgery (including Oral Surgery): Physician's fees for Inpatient surgery. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed the benefit for the one of such procedures for which the largest benefit is payable. Covered Expenses for surgery will be paid under this Inpatient surgery benefit or under the outpatient surgery benefit, but not both. Assistant surgeon fees are allowed at 25% of the surgery allowance.

5. Inpatient Anesthetist Services: in connection with Inpatient surgery.

6. Inpatient Registered Nurse’s Services: a) private duty nursing care only; b) while confined in a Hospital as an Inpatient; c) ordered by a licensed Physician; and d) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.

7. Inpatient Physician's Visits: when confined in a Hospital as an Inpatient, benefits are limited to one visit per day. Benefits do not apply when related to surgery. Covered Expenses for Physicians' visits will be paid under this Inpatient Physician's visits benefit or under the outpatient Physician's visits benefit, but not both on the same day.

8. Pre-admission Testing: limited to routine tests such as completed blood count; urinalysis; and chest X-rays. If otherwise payable under this Policy, major diagnostic procedures such as cat-scans and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. Pre-admission testing must occur within 7 working days prior to Hospital admission for this benefit to be payable.

9. Inpatient Psychotherapy.

10. Skilled Nursing Facility: Services and supplies for Skilled Nursing Facility room and board including normal daily services and supplies provided by the facility and other services and supplies, rehabilitative services, drugs and biologicals, and non-professional services furnished by the facility for medical care in it. In all events any one stay in a Skilled Nursing Facility is limited to 45 days.

11. Outpatient Surgery (including Oral Surgery): Physician's fees for outpatient surgery. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed the benefit for the one of such procedures for which the largest benefit is payable. Covered Expenses for surgery will be paid under this outpatient surgery benefit or under the Inpatient surgery benefit, but not both. Assistant surgeon fees are allowed at 25% of the surgery allowance.

12. Scheduled Outpatient Surgery Miscellaneous: in connection with outpatient surgery that is scheduled prior to its being performed. Benefits will be paid for services and supplies such as: the cost of the

operating room; anesthesia; drugs or medicines; therapeutic services; and supplies, for such surgery performed in a Hospital, an Outpatient Surgical Facility, or Physician's office. Non-scheduled surgery is not covered under this benefit.

13. Outpatient Anesthetist Services: in connection with scheduled outpatient surgery.

14. Outpatient Physician's Visits: benefits are limited to one visit per day. Benefits do not apply when related to surgery or physiotherapy.

15. Outpatient Physiotherapy/Occupational Therapy/Speech Therapy: benefits are limited as shown on the Schedule of Benefits. Service must be prescribed by a licensed physician, and such prescription is for a stated number of visits.

16. Outpatient Medical Emergency Expenses: benefits will be paid for the use of the emergency room and supplies.

17. Outpatient Diagnostic X-ray Services: if so noted in the Schedule of Benefits, separate maximums apply to positive and negative X-rays. Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.

18. Outpatient Radiation Therapy.

19. Outpatient Laboratory Procedures: laboratory procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.

20. Outpatient Test and Procedures: diagnostic services and medical procedures (includes dialysis) when performed by a Physician (excluding Physician's visits; physiotherapy; X-rays; and laboratory procedures).

21. Outpatient Injections: a) when administered in a Physician's office; and b) charged on the Physician's statement.

22. Outpatient Chemotherapy.

23. Outpatient Prescription Drugs. This includes hormone replacement therapy that is prescribed or ordered by a Physician for treating symptoms and conditions of menopause.

24. Outpatient Psychotherapy: Benefits are limited to one visit per day.

25. Ambulance Services.

26. Outpatient Braces and Appliances: a) when prescribed by a Physician; and b) a written prescription accompanies the claim when submitted. Replacement braces and appliances are not covered. Braces and appliances include durable, medical equipment, which is equipment, that: a) is primarily and customarily used to serve a medical purpose; b) can withstand repeated use; and c) generally is not useful to the person in the absence of Injury or Sickness. This includes Prosthetic and Orthotic Devices. No benefits will be paid for rental charges in excess of purchase price.

27. Inpatient and outpatient Consultant Physician Fees: when requested and approved by the attending Physician.

28. Dental Treatment: a) when performed by a Physician and b) made necessary by Injury to sound, natural teeth. Dental services and dental appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia are also covered. Routine dental care and treatment to the gums are not covered except as provided for under Pediatric Dental Services.

29. Medical Treatment Received in Home Country: If the Insured incurs expenses as the result of treatment for an Injury or Sickness in his or her Home Country, we will pay the expenses incurred not to exceed the maximum amount shown in the Schedule of Benefits.

For benefits to be payable under this part expenses must be incurred: (1) within 30 days from the date of the Insured's coverage terminated under this policy; and (2) for an Injury or Sickness that occurs while coverage under this Policy is in force.

30. Other Expense: if applicable and as noted on the Schedule of Benefits.

OPTIONAL EXPANDED BENEFITS

IMPORTANT INFORMATION: This policy provides coverage for Covered Persons who are not subject to the coverage mandate of the Patient Protection and Affordable Care Act (PPACA). But the Subscriber has requested the inclusion of certain expanded medical benefits required under PPACA.

The following provisions are added to this policy

Definitions
The following definitions shall apply:

Essential Health Benefits means benefits covered under the policy, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. Such benefits shall be consistent with those set forth under the PPACA and any regulations issued pursuant thereto.

Patient Protection and Affordable Care Act means the Patient Protection and Affordable Care Act (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act (Public Law 111-152).

Lifetime Dollar Limits
If the policy contains a lifetime dollar maximum on all benefits, such lifetime dollar maximum no longer applies. If the policy contains a lifetime dollar maximum(s) on specific benefits that are Essential Health Benefits, such lifetime dollar maximum(s) no longer apply.

Preventive Services
The following services shall be Covered Expenses under the policy without regard to any deductible, copayment, or coinsurance requirement that would otherwise apply:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
(3) with respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
(4) with respect to Covered Persons who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

Emergency Services
Emergency Services are covered without the need for any prior authorization determination.

Hospice Care Services: provides benefits for care of a terminally ill Covered Person with a life expectancy of six months or less. Services are covered only as part of a licensed health care program.

Hospice Care Services means a coordinated, interdisciplinary program of services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals by providing Palliative Care and supportive medical, nursing and other health services through home or Inpatient care during the illness to the terminally ill Covered Person.

Palliative Care means Treatment directed at controlling pain, relieving other symptoms of an Injury or Sickness, and focusing on the special needs of the patient as he or she experiences the stress of the dying process, rather than Treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

MANDATED BENEFITS

CLINICAL TRIALS BENEFIT

We will pay, subject to the same terms and conditions as a Sickness covered under the policy, the expenses for Routine Patient Care Costs incurred by a Covered Person who is a Qualified Individual participating in an Approved Clinical Trial. We do not cover the costs of items, services, or drugs that the sponsors of an approved clinical trial customarily provide at no cost to the Covered Person.

As used in this Benefit:

"Approved Clinical Trial" means:

1. A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:

    a. The National Institutes of Health;

    b. The Centers for Disease Control and Prevention;

    c. The Agency for Health Care Research and Quality;

    d. The Centers for Medicare and Medicaid Services;

    e. A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS or the Department of Defense, the Department of Veterans Affairs, the Department of Energy or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;

2. A study or investigation approved by the Food and Drug Administration ("FDA"), including those conducted under an investigational new drug or device application reviewed by the FDA; or

3. An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

"Routine Patient Care Costs" means:

1. Items, drugs, and services that are typically provided absent a clinical trial;

2. Items, drugs, and services required solely for the provision of the investigational item or service (such as the administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and

3. Items, drugs, and services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

1. The cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or items, drugs, or services provided solely to satisfy data collection and analysis needs; or

2. Items, drugs, or services customarily provided by the research sponsors free of charge for any Qualified Individual Enrolled in the trial.

"Qualified Individual" means a Covered Person who meets the following conditions:

1. The individual is eligible to participate in an Approved Clinical Trial; and

2. The Approved Clinical Trial is undertaken for the purposes of the prevention, early detection, treatment, or monitoring of cancer, chronic disease, or life-threatening illness.

COLORECTAL CANCER SCREENING

Expenses Incurred by a Covered Person for colorectal cancer screenings, performed in accordance with the latest screening guidelines issued by the American Cancer Society, are considered Covered Expenses and will be covered to the same extent as any other Covered Expenses incurred for the Treatment of a covered Sickness.

DIABETES TREATMENT BENEFIT

We will pay, subject to the same terms and conditions as a Sickness covered under the policy, the expenses incurred by a Covered Person for the treatment of diabetes.

The treatment of diabetes may include diabetes self-management training and educational services and equipment, supplies, medications, and laboratory procedures used to treat diabetes. This includes dialysis treatment.

EMERGENCY SERVICES BENEFIT

We will pay the Allowable Charges incurred by a Covered Person for emergency services that are due to a medical emergency. Emergency Services are covered without the need for any prior authorization determination. Benefits payable for emergency services are subject to the same terms and conditions that apply to the covered Injury or Sickness for which such services are required.

Additional Definitions - Wherever used in this benefit:

"Ancillary services" means standard medical procedures that are reasonably necessary for the diagnosis and treatment of a patient.

"Emergency services" means:

a) health care services furnished in the emergency department of a Hospital for the treatment of a medical emergency;
b) ancillary services routinely available to the emergency department of a Hospital for the treatment of a medical emergency; and
c) emergency medical services transportation. This includes ground ambulance and, when necessary, air ambulance.

HIV SCREENING TEST

We will pay the actual expense incurred by a Covered Person for one annual voluntary HIV screening test while the Covered Person is receiving emergency medical services, other than HIV Screening, at a Hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the medical emergency which caused the Covered Person to seek emergency services.

"HIV Screening Test" means the testing for the human immunodeficiency virus or any other identified causative agent of the acquired immune deficiency syndrome.

MAMMOGRAPHY AND CYTOLOGIC SCREENING BENEFITS

We will pay, subject to the same terms and conditions as a Sickness covered under this policy (including the application of benefit percentages and benefit maximums, but without application of any deductible amounts), the expenses incurred by a Covered Person for mammography examinations and cytologic screening as described below.

These benefits include coverage for:

a) a baseline mammogram for women; and

b) an annual screening mammogram for women; and

c) an annual cytologic screening for women; and

d) cervical cytologic screening for women upon certification by an attending Doctor that the test is Medically Necessary.

ORAL ANTI-CANCER DRUGS BENEFIT

We will pay, subject to the same terms and conditions as a Sickness covered under the policy, the Allowable Charges incurred for prescribed, orally administered anti-cancer medication used to kill or slow the growth of cancerous cells on the same basis as coverage provided for intravenously administered or injected cancer medications. The Covered Person receiving such prescribed oral medication shall have the option of having it dispensed at any appropriately licensed pharmacy.

PREVENTIVE AND PRIMARY CARE BENEFIT

We will pay, subject to the same terms and conditions as a Sickness covered under the policy, the Allowable Charges incurred for the preventive and primary care of a child covered under the policy. Such children will be covered under this benefit from birth to 21 years of age.

Additional Definitions - Wherever used in this benefit:

"Preventive and primary care" includes physical examinations, measurements, sensory screening, neuropsychiatric evaluations, development screening, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, sickle hemoglobinopathy, and other appropriate blood tests.

PROSTATE CANCER SCREENING BENEFIT

Expenses incurred by a Covered Person for prostate cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society for the ages, family histories, and frequencies referenced in such guidelines are considered Covered Expenses and will be payable under this Policy to the same extent as any other Covered Expenses incurred for the Treatment of a covered Sickness.

RECONSTRUCTIVE BREAST SURGERY BENEFITS

Expenses incurred by a Covered Person for Reconstructive Breast Surgery as described below are considered Covered Expenses and will be payable under this Policy to the same extent as any other covered surgery, provided such Reconstructive Surgery is required as a result of a mastectomy. Covered Expenses for reconstructive breast surgery will also include the cost of prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. Coverage Expenses will also include surgery on a non-diseased breast to establish symmetry with the diseased breast.

Payment of this benefit is subject to all other terms and conditions of this Policy.

Additional Definitions – Wherever used in this benefit:

"Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer.

HOME HEALTH CARE BENEFITS

Expenses incurred by a Covered Person for Home Health Care as described below are considered Covered Expenses and will be payable under this Policy to the same extent as any other Covered Expenses incurred for the Treatment of a covered Injury or Sickness.

"Home Health Care" means those nursing and other home health care services rendered to a Covered Person who is the patient in his or her place of residence, under the following conditions:

1. on a part-time and intermittent basis, except when full-time or 24-hour services are needed on a short-term (no more than 3 days) basis; and

2. if continuing hospitalization would have been otherwise required if home health care were not provided; and

3. pursuant to a Physician's written order and under a plan of care established by the responsible Physician working with a Home Health Care Provider. The physician must review the plan monthly and certify monthly that continued confinement in a Hospital would other wise be required. That Physician may not be related to the Home Health care provider by ownership or contract. All care plans must be established within 14 days following commencement of home health care.

"Home Health Care Provider" means an agency that is licensed as a home health agency.

"Home Health Care Services" means any of the following services which are Medically Necessary to achieve the plan of care referred to in condition (3) above and are provided for the care of the Covered Person: nursing care (furnished by or under the supervision of a Registered Nurse); physical therapy; occupational therapy; medical social work; nutrition services; speech therapy; home health aide services; medical appliances and equipment, drugs and medications, laboratory services and special meals, to the extent such items and services would be covered by this Policy if the Covered Person were in a Hospital; and any diagnostic or therapeutic service, including surgical services performed in a Hospital outpatient department, a Physician's office or any other licensed health care facility, to the extent such service would be covered by this Policy if performed while the Covered Person was confined in a Hospital as an Inpatient, provided that service is performed as part of the plan of care.

Limitations - Home Health Care Benefits are subject to the following limitations:

1. services must follow a Hospital confinement of at least 3 consecutive days. Services must begin not more than 3 days after the end of that confinement.

2. any visit by a member of a home health care team on any day will be considered one home health care visit. Benefits will be provided for no more than 60 home health care visits in any period of 12 consecutive months.

3. the amount payable for a home health care visit will not exceed for each of the first three days on which services are provided the daily room and board benefit provided by this Policy during the prior Hospital confinement; for each subsequent day of such services, the amount payable will not exceed one-half of the daily room and board benefit provided by this Policy during the prior Hospital confinement.

4. the services and supplies must be furnished and charged for by a Home Health Care Provider.

Payment of this benefit is subject to all other terms and conditions of this Policy.

SUBSTANCE ABUSE BENEFIT

Expenses Incurred by a Covered Person for the treatment of clinically significant substance abuse disorders identified in the most recent edition of the International Classification of Diseases of the Diagnostic and

Statistical Manual of the American Psychiatric Association as described below, are considered Covered Expenses and will be covered to the same extent as any other Covered Expenses incurred for the Treatment of a Covered Sickness.

Benefits and benefit maximums are as follows:

a) the process whereby a person who is intoxicated by or dependent on drugs or alcohol or both is assisted through the period of time necessary to eliminate the intoxicating agent from the body, while keeping the physiological risk to the patient at a minimum, shall be covered for up to 12 days annually.

b) Inpatient or Outpatient Services or any combination of those certified as necessary by a physician, psychologist, advanced practice registered nurse, or social worker and provided by a hospital, a non-hospital residential facility, an outpatient treatment facility, or a physician, a psychologist, an advanced practice registered nurse or a social worker shall be covered as follows:

   (1) up to 28 days per year for inpatient or residential care, in a hospital or non-hospital residential facility; and

   (2) up to 30 outpatient visits per year.

c) treatment regimens which include psychiatric, psychological, and other prescribed interventions shall be a covered benefit.

MENTAL ILLNESS BENEFITS

Expenses Incurred by a Covered Person for the treatment of clinically significant mental illness identified in the most recent edition of the International Classification of Diseases or of the Diagnostic and Statistical Manual of the American Psychiatric Association as described below, are considered Covered Expenses and will be covered to the same extent as any other Covered Expenses incurred for the Treatment of a Covered Sickness.

Benefits and benefit maximums are as follows:

a) treatment for inpatient or residential or residential care in a hospital or non-hospital residential facility, for up to 45 days per year;

b) outpatient benefits shall be 75% of covered expenses for the first 40 visits per year, and 60% of covered expenses for any outpatient visits thereafter for that year.

Inpatient and Outpatient Mental Illness Benefits shall be covered to the same extent as any other Covered Expenses incurred for the Treatment of a Covered Sickness, subject to the aforementioned benefit maximums.

EXCLUSIONS

Benefits are not payable under the 24-Hour Accident and Sickness Coverage for any of the following or loss that results therefrom:

1. Routine physical examinations and routine testing; preventive testing or Treatment; screening examinations or testing in the absence of Injury or Sickness, except as otherwise provided by the Policy.

2. Eye examinations; prescriptions or fitting of eyeglasses and contact lenses; eyeglasses, contact lenses or other Treatment for visual defects and problems, except as required as a result of a covered Injury. "Visual defects" means any physical defect of the eye that does or can impair normal vision.

3. Hearing examinations or hearing aids; or other Treatment for hearing defects and problems, except as required as a result of a covered Injury. "Hearing defects" means any physical defect of the ear that does or can impair normal hearing.

4. Dental care or Treatment other than care of sound, natural teeth and gums required due to an Injury resulting from an Accident while the Covered Person is insured under this Policy, and rendered within 12 months of the Accident.

5. War or any act of war, declared or undeclared; or while serving in the armed forces of any country (a pro-rata premium will be refunded for such period of service).

6. Participation in a riot or civil disorder; fighting or brawling, except in self-defense; commission of or attempt to commit a felony.

7. Suicide, attempted suicide or intentionally self-inflicted Injury while sane or insane.

8. Operating any vehicle while under the influence of alcohol or without being properly licensed and insured to do so.

9. Participation in, practice for, or orthopedic equipment and appliances used for; semi-professional sports; or professional sports.

10. Expenses greater than $10,000 for treatment of Injuries sustained by reason of participation in or, practice for; intercollegiate, interscholastic, intramural or club sports.

11. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planning, bungee jumping, or flight in any type of aircraft, except while riding as a fare-paying passenger on a regularly-scheduled airline.

12. Treatment, services or supplies provided by a Hospital or facility owned or run by the United States Government, unless a charge is made for such services in the absence of insurance; or in a Hospital which does not unconditionally require payment.

13. Cosmetic surgery, except cosmetic surgery which the Covered Person needs as the result of an Accident which happens while they are insured under this Policy or reconstructive surgery needed as a result of a congenital disease or abnormality of a covered newborn dependent child which has resulted in a functional defect.

14. Elective Treatments and voluntary testing except as otherwise provided under the Policy.

15. Injury or Sickness covered by Worker's Compensation or Employer's Liability Laws, or by any coverage provided or required by law (including, but not limited to group, group type, and individual automobile "No-Fault" coverage).

16. Charges used to meet any deductible, or in excess of the coinsurance level, or in excess of those considered Usual, Customary, and Reasonable Charges.

17. Treatment or services provided by any member of the Covered Person's immediate family; or for which no charge is normally made.

18. Rest cures or custodial care (whether or not prescribed by a Physician), or transportation.

19. Treatment, services or supplies provided or paid for by any governmental program or law, except Medicaid.

20. Nasal or Sinus Surgery (unless required due to an Injury resulting from an Accident while the Covered Person is insured under this Policy).

21. Organ Transplants.

22. The diagnosis and treatment of acne.

23. The diagnosis and treatment of Infertility.

24. The diagnosis and treatment of TMJ dysfunction, or skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia

25. Expenses incurred within the Covered Person's home country or country of regular domicile. Except for benefits under the Limited Home Country Benefit.

26. Treatment that is not incurred by a Covered Person while insured hereunder.

27. The diagnosis and treatment of venereal disease.

28. Injury sustained as a result of riding in or on a two or three-wheeled motor vehicle, or riding in or on a snowmobile.

29. Elective abortions.

30. Routine foot care, including the treatment of corns, calluses and bunions.

31. Nonmalignant warts, moles or lesions.

32. Impotence, whether organic or otherwise.

33. Sleeping disorders, including testing thereof.

Pre-existing Conditions Limitation: The Company will not pay benefits for a Pre-Existing Condition except as shown on the Schedule of Benefits. This does not apply if the Covered Person has been insured under the Policy for 6 months.

This limitation applies only to those Covered Persons and Descriptions of Benefits shown on the Schedule of Benefits.

Credit for Prior Coverage - A Covered Person, whose coverage under prior Creditable Coverage ended no more than 63 days before coverage under the Policy became effective, will have any applicable pre-existing condition limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, we will credit only the days of such coverage after the break.

Creditable Coverage means coverage under any of the following:

1. Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers= compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

2. The federal Medicare Program pursuant to Title XVIII of the Social Security Act;

3. The Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

4. Chapter 55 of Title 10, United State Code, the Civilian Health and Medical Program of the Uniformed Services;

5. A medical care program of the Indian Health Service or of a tribal organization;

6. A state health benefits risk pool;

7. A health plan offered under chapter 89 of Title 5, United States Code, the Federal Employees Health Benefits Program;

8. A public health plan as defined by federal regulations; or

9. A health benefit plan under section 5(e) of the Peace Corps Act.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy (including any endorsement or amendments), the signed application of the Policyholder (a copy of which will be attached to this Policy at issue), and the individual applications of Covered Persons, if any, constitute the entire contract. All statements made by the Policyholder or Covered Persons will be treated as representations and not warranties. No such statement will void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application. To be valid, any change or waiver must be in writing, must be signed by our President or Secretary and must be attached to this Policy. No agent has authority to change this Policy or to waive any part of this Policy.

CLERICAL ERROR: If a clerical error is made, it will not affect the insurance of any Covered Person. No error will continue the insurance of a Covered Person beyond the date it should end under the terms of this Policy.

EXAMINATION OF RECORDS AND AUDIT: The Company will be permitted to examine and audit the Policyholder's books and records at any time during the Policy Term and within two years after the final termination of this Policy, insofar as they relate to premium or subject matter of this insurance.

CONFORMITY WITH STATE LAWS: On the effective date of this Policy, any provision that is in conflict with the requirements of any state or federal law that applies to this Policy are automatically changed to satisfy the minimum requirements of such laws.

NOT IN LIEU OF WORKERS' COMPENSATION: This Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits.

GRACE PERIOD: A grace period of 31 days is granted for the payment of each premium due after the first premium, during which time the Policy continues in force. When a claim is paid, any premium due and unpaid may be deducted from the claim payment. The Policy will be reinstated lacking approval of an application of reinstatement, upon the 45th day following the date of conditional receipt of premium after the grace period unless the Company has previously notified the Policyholder in writing of its disapproval of the application.

POLICY TERMINATION: The Policy will continue in force while the required premiums are paid until either the Company or the Policyholder terminates the policy. At least 31 days advance written notice is required to terminate this Policy by either party.

SUBROGATION
(NOT APPLICABLE IN CALIFORNIA OR ARIZONA)

If the covered person is injured or becomes ill through the act or commission of another person, and if benefits are paid under this Policy due to that injury or Sickness, then to the extent the Covered Person recovers for the same Injury or Sickness from a third party, his or her insurer, or the Covered Person's uninsured motorist insurance, the Company will be entitled to a refund of all benefits it has paid up to the amount of such recovery. Further, the Company has the right to offset subsequent benefits payable to the Covered Person under the Policy against such recovery.

CLAIM PROVISIONS

NOTICE OF CLAIM: A claimant must give the Company or our authorized representative written notice of claim within 90 days after the date any loss occurs which is covered by this Policy. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify the Covered Person and the Policy Number.

CLAIM FORMS: Upon receiving written notice of claim, the Company will send claim forms to the claimant within fifteen days. If the Company does not furnish such forms, the claimant will satisfy the requirements of written proof of loss by sending the written proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

WRITTEN PROOF OF LOSS: Written proof of loss must be sent to the agent authorized to receive it. Written proof must be given within 90 days after the date of loss. If it cannot be provided within that time, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity should proof of loss be sent later than one year from the time proof is otherwise required.

TIME PAYMENT OF CLAIMS: When the Company receives written proof of loss, any benefits due will be paid immediately upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: If the Covered Person dies, any death benefits or other benefits unpaid at the time of death of the Covered Person will be paid to the beneficiary. If no beneficiary is on record with the Company or our authorized agent, payment will be made to the estate of the Covered Person. All other benefits will be paid to the Covered Person. If the Covered Person is (1) a minor; or (2) in our opinion, unable to give a valid release because of incompetence, we may pay any amount due to a parent, guardian, or other person actually supporting him. Any payment made in good faith will end our liability to the extent of the payment.

BENEFICIARY: The Covered Person may designate a beneficiary and he has the right to change the beneficiary at any time by written notice. If the Covered Person is a minor, their parent or guardian may exercise this right for them. The Covered Person will be the beneficiary for any covered dependents. If changed, the new beneficiary designation will be effective when the Company or the Administrator receives it. When received, the effective date is the date the notice was signed. The Company is not liable for any payments made by the Company before the change was received. The Company cannot attest to the validity of a change.

ASSIGNMENT: At the request of the Covered Person or their parent or guardian, medical benefits may be paid to the provider of these services. Any payment made in good faith will end our liability to the extent of the payment.

PHYSICAL EXAMINATIONS AND AUTOPSY: The Company has the right to have a Physician of our choice examine the Covered Person as often as is reasonably necessary. This section applies while a claim is pending or while benefits are being paid. The Company also has the right to request an autopsy in case of death, unless the law forbids it. The Company will pay the cost of any examination or autopsy.

LEGAL ACTIONS: No lawsuit or action in equity can be brought to recover on this Policy: (1) before 60 days following the date proof of loss was furnished to the Company; (2) after three years following the date proof of loss is required.

NOTICE OF APPEAL RIGHTS

Right to Appeal
A Covered Person has the right to appeal any decision or action taken by the Company to deny, reduce or terminate the provision of or payment for health care services requested or received under the policy. When the Company has denied, reduced, or terminated a requested service or payment for a service covered by the policy based on a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service, a Covered Person has the right to have the Company's decision reviewed by an independent review organization not associated with the Company.

The Company must provide certain written information, including the specific reason for the Company's decision and a description of the Covered Person's appeal rights and procedures, every time the Company makes a determination to deny, reduce or terminate the provision of or payment for health care services requested or received by a Covered Person under the policy.

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding medical necessity, you may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases:

District of Columbia Department of Health Care Finance, Office of the Health Care Ombudsman and Bill of Rights, 899 North Capital Street, NE, 6th floor, Washington, DC 20002 (1-877-685-6391 or fax 202-478-1397).

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

For Non-Medical Necessity cases:

Department of Insurance, Securities and Banking
1050 First St. N.E., Suite 801
Washington, D.C. 20002
(202) 727-8000
Fax: (202) 354-1085

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

Residents of the District of Columbia should know that licensed insurers who sell health insurance, life insurance, and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association").

The purpose of the Guaranty Association is to provide statutorily-determined benefits associated with covered policies and contracts in the unlikely event that a member insurer is unable to meet its financial obligations and is found by a court of law to be insolvent. When a member insurer is found by a court to be insolvent, the Guaranty Association will assess the other member insurers to satisfy the benefits associated with any outstanding covered claims of persons residing in the District of Columbia. However, the protection provided through the Guaranty Association is subjected to certain statutory limits explained under "Coverage Limitations" section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep the coverage in-force, with no change in contractual rights or benefits.

Coverage

The Guaranty Association, established pursuant to the Life and Health Guaranty Association Act of 1992 ("Act"), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code § 31-5401 *et seq*.), provides insolvency protection for certain types of insurance policies and contracts.

The insolvency protections provided by the Guaranty Association is generally conditioned on a person being 1) a resident of the District of Columbia and 2) the individual insured or owner under a health insurance, life insurance, or annuity contract issued by a member insurer, or insured under a group policy insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of District insureds are also covered under the Act, even if they reside in another state.

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- With respect to any one life, regardless of the number of policies, contracts, or certificates:
    - $300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
    - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
    - $300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
    - $300,000 for long-term care insurance benefits;
    - $300,000 for disability insurance benefits;
    - $500,000 for basic hospital, medical, and surgical insurance, or major medical insurance benefits;
    - $100,000 for coverage not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than $300,000 in benefits with respect to any one life ($500,000 in the event of basic hospital, medical and surgical insurance or major medical insurance).

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner of regardless of the number of policies owned.

Exclusions Examples

Policy or contract holders are not protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insureds that live outside of that state);
- Their insurer was not authorized to do business in the District of Columbia; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits or fees for services in connection with a policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contacts.

Consumer Protection

To learn more about the above referenced protections, please visit the Guaranty Association's website at www.dclifega.org. Additional questions may be directed to the District of Columbia Department of Insurance, Securities and Banking (DISB) and they will respond to questions not specifically addressed in this disclosure document.

Policy or contract holders with additional questions may contact either:

District of Columbia
Department of Insurance, Securities and Banking
810 First Street, N.E., Suite 701
Washington, DC 20002
(202) 727-8000

District of Columbia
Life and Health Guaranty Association
1200 G Street, N.W.
Washington, DC 20005
(202) 434-8771

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and the amounts of coverage provided under the Act. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on the insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association would cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any rights established in any policy or contract or under the Act.