

The Insurance Company of the State of Pennsylvania

(Herein called the Company)

The Company, in consideration of the payment of required premium, agrees with the Policy holder named in the Declarations (herein called Policy holder) to insure eligible persons of the Policyholder (herein individually called Insured Person), to the extent herein provided and subject to all of the exceptions, limitations and provisions of the Policy.

Disciple Missionary Medical

This document is a Program Summary outlining the full description in the Disciple Missionary Medical Policy, Number GLB 9126863

Administrator

Seven Corners

303 Congressional Boulevard - Carmel, IN 46032 USA

Seven Corners Assist must be contacted:

- As soon as non-emergency hospitalization is recommended.
- Within 48 hours of the first working day following an emergency admission.
- When your physician recommends any surgery, including outpatient.
- For emergency evacuation, repatriation of remains and assistance services.

To obtain a list of U.S. providers, contact Seven Corners Assist or visit www.Sevendcorners.com/PPO for a list of providers. Use of Provider Network for this program is for convenience only and does not guarantee reimbursement or discounts.

ELIGIBILITY: This program is available to citizens of any nation traveling outside of their Home Country who have paid premium as outlined in the enrollment application, and who have completed the enrollment form in complete detail are eligible for Disciple Missionary Medical. The Company maintains its right to investigate to verify that the eligibility requirements have been met. If and whenever the Company discovers that the eligibility requirements have not been met, its only obligation is refund of premium.

For the purposes of this program, persons between the ages of 14 days through 69 years are considered one class of Insured Person, and persons age 70 and over are considered another class of Insured Person.

The eligibility date for Dependent Child(ren) of a Named Insured (as defined) shall be determined in accordance with the following: (1) If a Named Insured has Dependent Child(ren) on the date he or she is eligible for insurance; or (2) If a Named Insured acquires Dependent Child(ren) after the Effective date, such Dependent Child(ren) becomes eligible on the date the Insured acquires a Dependent Child who is within the limits of a dependent, unmarried child set forth in the "Definition" section of the policy. Dependent Child(ren) eligibility expires concurrently with that of the Named Insured.

EFFECTIVE DATE

Effective Date under the program shall become effective at 12:01 AM on the latest of the following dates:

1. The Insured Person's departure from his home country; or
2. The date the application and premium are received by the Administrator; or
3. The date the application and premium are accepted by the Administrator; or
4. The date requested on the application.

Dependent Child(ren) coverage will not be effective prior to that of the Named Insured.

EXPIRATION DATE

The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

1. The date shown on the insurance confirmation card, for which the premium is paid; or
2. The date the Insured Person returns to his Home Country; or
3. 12 months after the Insured Person's original effective date;
4. The date of entry into active duty military service.
5. The date the master policy terminates (unless the Company agrees, in writing, to permit coverage to continue to the end of the period for which premiums have been paid in lieu of a return of unearned premiums);
6. In addition, for Dependent Child(ren), coverage expires the date the Named Insured(s) coverage expires or the date they cease to be considered a Dependent Child.

DEFINITIONS

"CONGENITAL ANOMALIES" means congenital abnormality, congenital malformation, birth defect) is a condition(s) which is present at the time of birth which varies from the standard presentation, regardless of the causation. Also Known As: Hereditary

"COVERED MEDICAL EXPENSES" means reasonable charges which are: 1) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 2) made for services and supplies not excluded under the policy; 3) made for services and supplies which are a Medical Necessity; 4) made for services included in the Schedule of Benefits; and 5) in excess of the amount stated as a deductible, if any. Covered medical expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

"DEDUCTIBLE" means the amount stated in the Schedule of Benefits or any endorsement to the policy as a deductible. Such amount will be subtracted from the amount or amounts charged and otherwise payable as Covered Medical Expenses. The deductible will apply per occurrence (for each Injury or Sickness) as specified in the Schedule of Benefits.

"DEPENDENT CHILD(REN)" means a Named Insured's dependent, unmarried children living with the Named Insured. This includes stepchildren, legally adopted children and children of adopting parents pending adoption procedures. Children shall cease to be dependent on the first to occur of: (1) the end of the month in which they marry; or (2) the end of the month in which they attain the age of nineteen (19) years. The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both: (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (2) chiefly dependent upon the Insured Person for support and maintenance. Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company upon request following the child's attainment of the limiting age. If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsection (1) and (2).

“EXCESS PROVISION” means the plan benefits are payable for covered expenses not covered and payable by any other plan providing medical expense benefits. If there is no other valid and collectible benefits available from any other source, this plan will pay the covered expenses up to the limits of the policy.

“HOME COUNTRY” means the country where the Insured Person’s Passport was issued.

“HOSPITAL” means a licensed or properly accredited general Hospital which; 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured person as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home, or an institution specializing in or primarily treating Mental and Nervous Disorders.

“HOSPITAL CONFINED/HOSPITAL CONFINEMENT” means confined in a Hospital for at least 18 hours by reason of an Injury or Sickness for which benefits are payable.

“INJURY” means bodily Injury: 1) directly and independently caused by specific accident which is unrelated to any pathological, functional, or structural disorder or Injury; 2) treated by a Physician within 30 days after the date of accident; and 3) which causes loss during the term of the policy.

“INSURED PERSON” means: 1) the Named Insured; and 2) Dependent Child(ren) of the Named Insured, if: 1) the Dependent Child(ren) is properly enrolled in the program; and 2) the appropriate dependent premium has been paid. The term “Insured” also means Insured Person.

“INTENSIVE CARE” means (1) a specifically designated facility of the Hospital that provides the highest level of medical care; and (2) which is restricted to those patients who are critically ill or injured.

Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement.

“MEDICAL EMERGENCY” means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in: (1) Death; (2) Permanent placement of the Insured’s health in jeopardy; (3) Serious impairment of bodily functions; or (4) Serious and permanent dysfunction of any body organ or part. Expenses incurred for “Medical Emergency” will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor injuries or minor Sicknesses.

“MEDICAL NECESSITY/MEDICALLY NECESSARY” means those services or supplies provided or prescribed by a Hospital or Physician which are: (1) Essential for the symptoms and diagnosis or treatment of the Sickness or Injury; (2) Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury; (3) In accordance with the standards of good medical practice; (4) Not primarily for the convenience of the Insured, or the Insured’s Physician; and (5) The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and 2) the Insured cannot receive safe and adequate care as an outpatient. The policy only provides payment for services, procedures and supplies which in the judgement of the Company are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement.

“MENTAL AND NERVOUS DISORDER” means a Sickness that is a mental, emotional or behavioral disorder.

“MYOCARDIAL INFARCTION” shall mean an acute and emergent onset of any of the conditions and/or diseases described and coded in the International Coding of Diseases version 9 (ICD9), code sequences 410.0 – 410.9 and 414.1 – 419.9.

“NAMED INSURED” means an eligible person who: 1) has completed an application; and 2) that application and the appropriate premium for coverage has been paid and accepted by the Administrator.

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

“PHYSIOTHERAPY” means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

“PRE-EXISTING CONDITION” means the existence of symptoms within the six (6) months (12 months for Insured Persons 70 and older) immediately prior to the Insured Person’s Effective Date under the policy; any condition which originates, is diagnosed, treated or recommended for treatment within six (6) months (12 months for Insured Persons 70 and older) immediately prior to the Insured Person’s Effective Date under the policy; or congenital conditions.

“PRESCRIPTION DRUGS” means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

“SICKNESS” means Sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under the policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

“SOUND, NATURAL TEETH” means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed or defective.

“SERVICE PROVIDER” shall mean a Hospital, Hospice, Convalescent/skilled nursing facility, ambulatory surgical center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, alcohol or drug dependency treatment center, birthing center, Physician, Dentist, chiropractor, licensed medical practitioner, nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility that the Company approves to provide services under the Certificate.

“STROKE” shall mean an acute and emergent onset of any of the conditions and/or diseases described and coded in the International Coding of Diseases version 9 (ICD9), code sequence 430-438.9.

SCHEDULE OF BENEFITS

INJURY AND SICKNESS MEDICAL BENEFITS (PART A)

Maximum Benefit Limit Per Sickness or Injury:

Ages 14 days through 69: Option \$50,000 (Plan A), Option \$75, 000 (Plan B), \$100,000 (Plan C) or Option \$130,000 (Plan D)
 Age 70 and over: Option \$50,000 (Plan J) or Option \$70,00 (Plan K)

Deductible Per Person Per Sickness or Injury:

Ages 14 days through 69: Option \$0, \$50 or \$100
 Age 70 and over: Option \$100 or \$200

No Coinsurance applies.

Age 14 Days through 69	Plan A	Plan B	Plan C	Plan D
INPATIENT	\$50,000 Max per Injury/Sickness	\$75,000 Max per Injury/Sickness	\$100,000 Max per Injury/Sickness	\$130,000 Max per Injury/Sickness
Hospital Room & Board including Laboratory Tests, X-Rays, Prescription Medical and other miscellaneous	Up to \$1400/day, 30 day max	Up to \$1675/day, 30 day max	Up to \$1950/day, 30 day max	Up to \$2535/day, 30 day max
Hospital Intensive Care Unit	Additional \$660/day, 8 day max	Additional \$755/day, 8 day max	Additional \$850/day, 8 day max	Additional \$1105/day, 8 day max

Surgical Treatment	Up to \$3300	Up to \$4400	Up to \$5500	Up to \$7150
Anesthetist	Up to \$825	Up to \$1100	Up to \$1375	Up to \$1775
Assistant Surgeon	Up to \$825	Up to \$1100	Up to \$1375	Up to \$1775
Physician's Non-Surgical Visits	Up to \$55/visit, 1/day, 30 visits max	Up to \$70/visit, 1/day, 30 visits max	Up to \$85/visit, 1/day, 30 visits max	Up to \$110/visit, 1/day, 30 visits max
A Consulting Physician, when requested by attending Physician	Up to \$450	Up to \$475	Up to \$500	Up to \$650
Private Duty Nurse	Up to \$550	Up to \$550	Up to \$550	Up to \$700
Pre-Admission Tests w/in 7 days before Hospital admission	Up to \$1100	Up to \$1100	Up to \$1100	Up to \$1450
OUTPATIENT				
Surgical Treatment	Up to \$3300	Up to \$4400	Up to \$5500	Up to \$7150
Anesthetist	Up to \$825	Up to \$1100	Up to \$1375	Up to \$1775
Assistant Surgeon	Up to \$825	Up to \$1100	Up to \$1375	Up to \$1775
Physician's Non-Surgical / Urgent Care Visits	Up to \$55/visit, 1/day, 10 visits max	Up to \$70/visit, 1/day, 10 visits max	Up to \$85/visit, 1/day, 10 visits max	Up to \$110/visit, 1/day, 10 visits max
Diagnostic X-rays & Lab Services	Up to \$450 - Additional \$250 - One Cat scan, PET scan or MRI	Up to \$475 - Additional \$375 - One Cat scan, PET scan or MRI	Up to \$500 - Additional \$500 - One Cat scan, PET scan or MRI	Up to \$650 - Additional \$600 - One Cat scan, PET scan or MRI
Hospital Emergency Room (all expenses incurred therein)	Up to a maximum of \$330	Up to a maximum of \$440	Up to a maximum of \$550	Up to a maximum of \$700
Prescription Drugs	Up to \$100	Up to \$125	Up to \$150	Up to \$200
Outpatient Surgical Facility	Up to \$1000	Up to \$1050	Up to \$1100	Up to \$1400
OTHER TREATMENT AND SERVICES				
Ambulance Services	Up to \$450	Up to \$450	Up to \$450	Up to \$450
Initial Orthopedic Prosthesis/brace	Up to \$1100	Up to \$1200	Up to \$1300	Up to \$1700
Chemotherapy and/or radiation therapy	Up to \$1100	Up to \$1225	Up to \$1350	Up to \$1750
Dental Treatment for Injury to Sound, Natural Teeth	Up to \$550	Up to \$550	Up to \$550	Up to \$550
Mental & Nervous Disorder & Substance Abuse	Same as any Sickness	Same as any Sickness	Same as any Sickness	Same as any Sickness
Physiotherapy	Up to \$40/visit, 1/day, 12 visits max	Up to \$40/visit, 1/day, 12 visits max	Up to \$40/visit, 1/day, 12 visits max	Up to \$40/visit, 1/day, 12 visits max
Emergency Evacuation	\$50,000	\$50,000	\$50,000	\$50,000
Repatriation of Remains	\$7,500	\$7,500	\$7,500	\$7,500
Political Evacuation and Repatriation	Up to \$10,000	Up to \$10,000	Up to \$10,000	Up to \$10,000
Emergency Reunion	Up to \$10,000	Up to \$10,000	Up to \$10,000	Up to \$10,000
Return of Minor Children	Up to \$10,000	Up to \$10,000	Up to \$10,000	Up to \$10,000
Felonious Assault Benefit	Up to \$10,000	Up to \$10,000	Up to \$10,000	Up to \$10,000
Coma Benefit	Up to \$10,000	Up to \$10,000	Up to \$10,000	Up to \$10,000
Furlough Coverage	Up to 90 days per 12 months	Up to 90 days per 12 months	Up to 90 days per 12 months	Up to 90 days per 12 months
Terrorism	Same as any Sickness	Same as any Sickness	Same as any Sickness	Same as any Sickness
AD&D Principal Sum	\$25,000 Common Carrier	\$25,000 Common Carrier	\$25,000 Common Carrier	\$25,000 Common Carrier
OPTIONAL PRE-EX BENEFIT	Plan A	Plan B	Plan C	Plan D
PRE-EXISTING CONDITIONS (the above maximum schedule still applies)	Up to \$5,000 in coverage for Myocardial Infarction (heart attack) or Stroke	Up to \$5,000 in coverage for Myocardial Infarction (heart attack) or Stroke	Up to \$5,000 in coverage for Myocardial Infarction (heart attack) or Stroke	Up to \$5,000 in coverage for Myocardial Infarction (heart attack) or Stroke
If an insured person turns 70 years old during the purchased coverage period, the 70 and over benefit schedule becomes effective upon the day the insured turns 70. Individuals with the \$100,000 or \$130,000 per injury or sickness policy maximum will receive the \$70,000 per injury or sickness schedule for age 70 and older. Individuals with the \$75,000 or \$50,000 per injury or sickness policy maximum will receive the \$50,000 per injury or sickness schedule for age 70 and older.				

Age 70-99	Plan J	Plan K
INPATIENT	\$50,000 Max per Injury/Sickness	\$70,000 Max per Injury/Sickness
Hospital Room & Board including Laboratory Tests, X-Rays, Prescription Medical and other miscellaneous	Up to \$1,050/day, 30 day max	Up to \$1,470/day, 30 day max
Hospital Intensive Care Unit	Additional \$460/day, 8 day max	Additional \$640/day, 8 day max
Surgical Treatment	Up to \$2,750	Up to \$3,850
Anesthetist	Up to \$685	Up to \$960
Assistant Surgeon	Up to \$685	Up to \$960
Physician's Non-Surgical Visits	Up to \$55/visit, 1/day, 30 visits	Up to \$75/visit, 1/day, 30 visits max

A Consulting Physician, when requested by attending Physician	Up to \$400	Up to \$560
Private Duty Nurse	Up to \$450	Up to \$450
Pre-Admission Tests w/in 7 days before Hospital admission	Up to \$775	Up to \$1085
OUTPATIENT		
Surgical Treatment	Up to \$2,750	Up to \$3850
Anesthetist	Up to \$685	Up to \$960
Assistant Surgeon	Up to \$685	Up to \$960
Physician's Non-Surgical / Urgent Care Visits	Up to \$55/visit, 1/day, 10 visits	Up to \$75/visit, 1/day, 10 visits max
Diagnostic X-rays & Lab Services	Up to \$400 - Additional \$250 - One Cat scan, PET scan or MRI	Up to \$560 – Additional \$300 – One Cat scan PET or MRI
Hospital Emergency Room (all expenses incurred therein)	Up to \$250	Up to \$350
Prescription Drugs	Up to \$80	Up to \$110
Outpatient Surgical Facility	Up to \$850	Up to \$1190
OTHER TREATMENT AND SERVICES		
Ambulance Services	Up to \$450	Up to \$450
Initial Orthopedic Prosthesis/brace	Up to \$850	Up to \$1190
Chemotherapy and/or radiation therapy	Up to \$850	Up to \$1190
Dental Treatment for Injury to Sound, Natural Teeth	Up to \$550	Up to \$550
Mental & Nervous Disorder & Substance Abuse	Same as any Sickness	Same as any Sickness
Physiotherapy	Up to \$40/visit, 1/day, 12 visits	Up to \$40/visit, 1/day, 12 visits max
Emergency Evacuation	\$50,000	\$50,000
Repatriation of Remains	\$7,500	\$7,500
Political Evacuation and Repatriation	Up to \$10,000	Up to \$10,000
Emergency Reunion	Up to \$10,000	Up to \$10,000
Return of Minor Children	Up to \$10,000	Up to \$10,000
Felonious Assault Benefit	Up to \$10,000	Up to \$10,000
Coma Benefit	Up to \$10,000	Up to \$10,000
Furlough Coverage	Up to 90 days per 12 months of coverage (or pro-rata)	Up to 90 days per 12 months of coverage (or pro-rata)
Terrorism	Same as any Sickness	Same as any Sickness
AD&D Principal Sum	\$25,000 Common Carrier	\$25,000 Common Carrier
OPTIONAL PRE-EX BENEFIT	Plan J	Plan K
PRE-EXISTING CONDITIONS (the above maximum schedule still applies)	Up to \$3,000 in coverage for Myocardial Infarction (heart attack) or Stroke	Up to \$3,000 in coverage for Myocardial Infarction (heart attack) or Stroke

EMERGENCY EVACUATION AND REPATRIATION OF REMAINS (PART B)

<u>BENEFIT</u>	<u>MAXIMUM AMOUNT</u>
Emergency Evacuation	\$50,000 maximum benefit
Repatriation of Remains	\$7,500 maximum benefit

COMMON CARRIER ACCIDENTAL DEATH & DISMEMBERMENT (PART C)

<u>BENEFIT</u>	<u>PRINCIPAL SUM</u>
Accidental Death & Dismemberment	\$25,000

A. MEDICAL EXPENSE BENEFITS – INJURY AND SICKNESS

When a covered Injury or Sickness requires treatment by a Physician, the policy will provide benefits up to the scheduled amount as listed in the Schedule of Benefits for Medically Necessary Covered Medical Expenses which exceed the deductible per person for each Injury or Sickness. Payment for any Covered Medical Expense will be no more than the Benefit Limit shown for it. The total payable for all Covered Medical Expenses will be no more than the Maximum Benefit Limit per Sickness or Injury. Benefits are subject to the Excess Provision.

Covered Medical Expenses will be paid under the Schedule of Benefits for loss:

- 1) Due to Injury to an Insured Person provided that treatment by a Physician: a) begins within 30 days after date of Injury; and b) is received within 12 months (32 weeks for Insured Persons age 70 and over) after date of Injury; or
- 2) Due to Sickness of an Insured Person provided Covered Medical Expenses are incurred within 12 months (32 weeks for Insured Persons age 70 and over) after the date of first treatment for such Sickness.

If a benefit is designated in the Schedule of Benefits, Covered Medical Expenses include:

- 1) Room and Board Expense: 1) daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged for by the Hospital.
- 2) Intensive Care.
- 3) Hospital Miscellaneous Expenses: 1) while Hospital Confined; or 2) for pre-admission expenses for being Hospital Confined. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; x-ray examination; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies.
- 4) Physiotherapy (inpatient).
- 5) Surgery: Physician's fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. Covered medical expenses will be paid under this inpatient surgery benefit; or under the outpatient surgery benefit, but not for both.
- 6) Charges made for the cost and administration of anesthetics: in connection with inpatient surgery. Anesthetist Services: in connection with inpatient surgery.

- 7) Private Duty Nurse's Services: 1) private duty nursing care only; 2) while Hospital Confined; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.
- 8) Physician's Visits: when Hospital Confined. Benefits are limited to one Physician's visit per day. Benefits do not apply when related to surgery. Covered medical expenses will be paid under the inpatient benefit or under the outpatient benefit for Physician's Visits but not both.
- 9) Pre-admission Testing: limited to routine tests such as: complete blood count; urinalysis; and chest x-ray. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit.
- 10) Mental and Nervous Disorder (inpatient): the benefits and the maximum amounts are specified in the Schedule of Benefits. Benefits are limited to one Physician's visit per day.
- 11) Surgery (Outpatient): Physician's fees for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. Covered medical expenses will be paid under this outpatient surgery benefit; or under the inpatient surgery benefit, but not both.
- 12) Day Surgery Miscellaneous (Outpatient): in connection with outpatient day surgery; excluding non-scheduled surgery, and surgery performed in a Hospital emergency room, trauma center, Physician's office, or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room, laboratory tests and x-ray examinations including professional fees, anesthesia, drugs or medicines, therapeutic services and supplies.
- 13) Anesthetist (Outpatient): in connection with outpatient surgery.
- 14) Physician's Visits (Outpatient): Includes injections administered during visit. Benefits do not apply when related to surgery or Physiotherapy. Covered medical expenses will be paid under the outpatient benefit or under the inpatient benefit for Physician's visits but not both.
- 15) Medical Emergency Expenses (Outpatient): only in connection with a Medical Emergency as defined. Benefits will be paid for the use of the emergency room and supplies.
- 16) Radiation Therapy (Outpatient)
- 17) Chemotherapy (Outpatient)
- 18) Prescription Drugs (Outpatient)
- 19) Mental and Nervous Disorder (Outpatient): the benefits and the maximum amounts are specified in the Schedule of Benefits. Benefits are limited to one Physician's visit per day.
- 20) Ambulance Service.
- 21) Braces and Appliances: 1) when prescribed by a Physician; and 2) 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: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. No benefits will be paid for rental charges in excess of purchase price.
- 22) Consultant Physician Fees: when requested and approved by the attending Physician.
- 23) Dental Treatment: 1) performed by a Physician; and 2) made necessary by Injury to Sound, Natural Teeth. Routine dental care and treatment to the gums are not covered.
- 24) Alcoholism/Drug Abuse Treatment: the benefits and the maximum amounts are specified in the Schedule of Benefits.

B. EMERGENCY EVACUATION

The Company shall pay benefits for Covered Expenses incurred up to \$50,000, if an Injury or Sickness commencing during the Period of Coverage results in the Medically Necessary Emergency Medical Evacuation or Repatriation of the Insured Person. An Emergency Evacuation must be ordered by a legally licensed Physician who certifies that the severity of the Insured Person's Injury or Sickness warrants the emergency evacuation of the Insured Person. Benefits are subject to the Excess Provision.

Emergency Medical Evacuation or Repatriation means: a) the Insured Person's medical condition warrants immediate transportation from the place where the Insured Person is located to the nearest Hospital where medical treatment can be obtained; or b) after being treated at a local Hospital, the Insured Person's medical condition warrants transportation to the place where he or she resides to obtain further medical treatment or to recover; or c) both a) and b) above.

Covered expenses, up to the maximum, for transportation, medical services and medical supplies necessarily incurred in connection with emergency evacuation of the Insured Person.

All transportation arrangements made for evacuating the Insured Person must be by the most direct and economical route. Seven Corners Assist must make all arrangements and must authorize all expenses in advance for any Emergency Evacuation benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact Seven Corners Assist in advance.

Covered expenses must be: (a) recommended by the attending Physician; (b) required by the standard regulations of the conveyance transporting the Insured Person; and (c) authorized in advance by Seven Corners Assist.

Transportation means any land, water or air conveyance required to transport the Insured Person during an emergency evacuation. Transportation includes, but is not limited to, air ambulance, land ambulance, and private motor vehicles.

C. REPATRIATION OF REMAINS

The Company will pay the reasonable Covered Expenses incurred up to return the Insured Person's remains to his/her Home Country, if he or she dies, not to exceed the maximum of \$7,500.00. Benefits are subject to the Excess Provision. Seven Corners Assist must make all arrangements and must authorize all expenses in advance for any Repatriation of Remains benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact Seven Corners Assist in advance.

Covered expenses include, but are not limited to, expenses for embalming, cremation, coffins and transportation.

D. POLITICAL EVACUATION AND REPATRIATION OF REMAINS, Maximum Benefit Amount: \$10,000

If due to political or military events in a host country, a formal recommendation from the appropriate authorities is issued for the Insured to leave the host country or the Insured is expelled or declared persona non-grata by the host country, all reasonable expenses incurred for transportation to the nearest place of safety or for repatriation to the Insured's home country or country of residence are covered up to a maximum of **\$10,000**. Evacuation must occur within 10 days of any such event. Coverage will apply to the most appropriate and economical means consistent under the circumstances with your health & safety. Evacuation costs will be paid once per Insured per occurrence. In the event this benefit is needed, arrangements must be made by the Seven Corners Assist.

For **Political Evacuation and Repatriation**, this insurance does not cover: 1) Losses recoverable under any other insurance or through an employer; 2) Losses arising from or attributable to a) dishonest or criminal acts committed or attempted by the Insured, b) alleged violation of the laws of the host country, unless the company determines such allegations to be fraudulent, or c) failure to maintain required documents or visas; 3) Losses attributable to a) debt, insolvency, commercial failure, or the repossession of any property, b) Insured's non-compliance with a contract or license or c) implementation of illegally contributed exchange rates; 4) Losses due to liability assumed by the Insured under any contract.

E. EMERGENCY MEDICAL REUNION, Maximum Benefit Amount: \$10,000

When Emergency Medical Evacuation or Repatriation occurs, the Company will arrange and pay, up to **\$10,000**, for round trip economy-class transportation for one individual selected by the Insured Person, from the Insured Person's Home Country to the location where the Insured Person is hospitalized and return to the Home Country. Emergency Medical Reunion must be recommended by the attending Physician. The benefits payable will include: (1) The cost of a round trip economy air fare; (2) Reasonable travel and accommodation expenses (not to exceed **\$200** per day) incurred in relation to the maximum of **\$10,000**. (3) The period of Emergency Medical Reunion is not to exceed 10 days, including travel.

F. RETURN OF MINOR CHILD(REN), Maximum Benefit Amount: \$10,000

Should the Insured Person be traveling alone with a Minor Child(ren) and is hospitalized because of a covered illness or injury and the Minor Child(ren), under age 19, is left unattended, the Company will arrange and pay, up to \$10,000, for one way economy fares to their Home Country. These arrangements will be made at no cost to the Insured Person. Meals and lodging are the responsibility of the Insured Person. If an attendant/escort is necessary to insure the safety and welfare of Minor Child(ren), the Company will arrange and pay for these services to the limit stated in the Schedule of Benefits.

G. FELONIOUS ASSAULT BENEFIT, Maximum Benefit Amount: \$10,000

The Company will pay 100% of the Maximum Amount when the Insured suffers one or more losses for which benefits are payable under the Accidental Death Benefit, Accidental Dismemberment Benefit or Coma Benefit provided by the Policy as a result of a Felonious Assault:

- 1. That is not a moving violation as defined under the applicable government motor vehicle laws; and
2. That is not an act of an Immediate Family Member, another Insured or an individual who resides with the Insured on a permanent basis.

Only one benefit is payable for all losses as a result of the same Felonious Assault.

Felonious Assault - as used, means any willful or unlawful use of force upon the Insured: (1) with the intent to cause bodily injury to the Insured; and (2) that results in bodily harm to the Insured; and (3) that is a felony or a misdemeanor in the jurisdiction in which it occurs.

H. COMA BENEFIT, Maximum Benefit Amount: \$10,000

If injury renders an Insured Comatose within 90 days of the date of the accident that caused the Injury, and if the Coma continues for a period of 30 consecutive days, the Company will pay a monthly benefit equal to 1% of the Maximum Amount. No benefit is provided for the first 30 days of the Coma. The benefit is payable monthly as long as the Insured remains Comatose due to that Injury, but ceases on the earliest of: (1) the date the Insured ceases to be Comatose due to that Injury; (2) the date the Insured dies; or (3) the date the total amount of monthly Coma benefits paid for all Injuries caused by the same accident equals the Maximum Amount. The Company will pay benefits calculated at a rate of 1/30th of the monthly benefit for each day for which the Company is liable when the Insured is Comatose for less than a full month. Only one benefit is provided for any one month of Coma, regardless of the number of Injuries causing the Coma.

The Company reserves the right, at the end of the first 30 consecutive days of Coma and as often as it may reasonably require thereafter, to determine, on the basis of all the facts and circumstances, that the Insured is Comatose, including, but not limited to, requiring an independent medical examination provided at the expense of the Company.

Coma/Comatose - as used in this Rider, means a profound state of unconsciousness from which the Insured cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician.

I. FURLOUGH COVERAGE

Incidental Trips to Your Home Country: This benefit covers the Insured Person for incidental trips to his or her Home country (90 days per 12 months of purchased coverage or pro rata thereof. The benefits available during Furlough Coverage are the same as the standard benefits. In order to utilize Furlough Coverage, you must first leave the country before returning home on an incidental trip

J. COMMON CARRIER ACCIDENTAL DEATH AND DISMEMBERMENT INDEMNITY

Accidental Death & Dismemberment Coverage shall apply only to covered accidents sustained by an Insured Person:

- 1. While riding as a passenger (but not as a pilot, operator or member of the crew) in or on (including getting in or out of, or on or off of):
A) any land, water or air conveyance operated under a license for the transportation of passengers for hire; or
B) any Military Air Transport Aircraft; or
2. By being struck down by any aircraft.
The Company shall pay an indemnity determined from the Table of Losses below if an Insured Person sustains a loss stated therein resulting from Injury, provided that:
(a) such loss occurs within 365 days after the date of accident causing such loss; or
(b) the indemnity payable for any such loss shall be the amount stated opposite such loss in said Table and the Principal Sum stated therein shall be the amount stated in the Schedule of Benefits, as applicable to such person and this Coverage; and
(c) if more than one loss stated in said Table is sustained as the result of one accident, only one of the amounts so stated in said Table, the largest, shall be payable.

Table with 2 columns: For Loss of, Indemnity. Rows include Life, Both Hands or Both Feet or Sight of Both Eyes, One Hand and One Foot, Either Hand or Foot and Sight of One Eye, Either Hand or Foot, Sight of One Eye. The term 'loss' as used herein shall mean with regard to hands and feet, actual severance through or above wrist or ankle joints, and with regard to eyes, entire irrecoverable loss of sight.

K. AGGREGATE LIMIT OF INDEMNITY

The Aggregate Limit of Indemnity of \$125,000 shall be the total limit of the Company's liability for all indemnities payable under Accidental Death and Dismemberment Indemnity with respect to all classes of Insured Persons arising out of Injury sustained by two or more Insured Persons as the result of any one accident.

If the total of such indemnity exceeds said Aggregate Limit of Indemnity, the Company shall not be liable to any one such Insured Person for a greater proportion of such Insured Person's Indemnity afforded by the Accidental Death and Dismemberment Indemnity than said Aggregate Limit of Indemnity bears to the total Indemnities afforded by this Accident Death and Dismemberment Indemnity to all such Insured Persons.

L. OPTIONAL PRE-EXISTING CONDITIONS BENEFITS

Disciple Missionary Medical now offers the following benefit: Should the Insured Person suffer a Myocardial Infarction or Stroke during the Period of Coverage and it is determined to be a "Pre-Existing Condition", coverage for those expenses will be covered up to the Pre-Existing Condition Benefit maximum, according to the Schedule of Benefits.

M. EXCESS PROVISION

All benefits, except Accidental Death and Dismemberment, shall be in excess of all other valid and collectible insurance and shall apply only when such benefits are exhausted. If an Insured's Injury or Sickness is due to an act or omission of another, benefits payable by this plan are subject to recovery from amounts eventually paid to the Insured by or on behalf of, the other person.

PREMIUM RATES - PREMIUMS CURRENTLY IN FORCE CAN BE FOUND ON THE CURRENT BROCHURE FOR DISCIPLE MISSIONARY MEDICAL

An Eligible Person may enroll for a period of coverage ranging from 5 days to 12 months, subject to the following rules: Five days premium is the minimum acceptable premium; twelve month's premium is the maximum acceptable premium; and the full premium is payable at the time of enrollment.

If coverage is initially purchased for a minimum of three months, coverage may be renewed, if available, for additional periods at the premium rate in force at the time of renewal. The maximum total period of coverage for any one Insured Person cannot exceed 12 months. There are no grace periods for renewals. Once the policy has lapsed, you would need to return to your home country in order to reapply. Please note: Once you reapply for a new policy, the pre-existing condition(s) look back starts over.

REFUND PROCEDURE

Seven Corners realizes that there is uncertainty in international travel. Refund of total plan cost will only be considered if written request is received by Seven Corners prior to the Effective Date of Coverage. If written request is received after the Effective Date of coverage, the unused portion of the plan cost may be refunded minus a cancellation fee, provided no claim has been submitted to Seven Corners for reimbursement.

EXCLUSIONS AND LIMITATIONS

No benefits will be paid for loss or expense caused by, contributed to, or resulting from:

- 1) Pre-Existing Conditions; as defined
- 2) No benefits will be paid for loss or expense caused by, contributed to, or resulting any loss that occurs while traveling or enrolling solely for the purpose of obtaining medical treatment, while on a waiting list for a specific treatment, or while traveling against the advice of a Physician;
- 3) Routine physical, inoculations or other examinations where there are no objective indications of impairment of normal health, or well baby care;
- 4) Eye examinations; prescriptions or fitting of eyeglasses and contact lenses; or other treatment for visual defects and problems. "Visual Defects" means any physical defect of the eye which does or can impair normal vision;
- 5) Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing Defects" means any physical defect of the ear which does or can impair normal hearing;
- 6) Dental treatment, except as the result of Injury to Sound, Natural Teeth as stated in the Schedule of Benefits;
- 7) Professional services rendered by a member of the Insured Person's immediate family, or anyone who lives with the Insured Person;
- 8) Services or supplies not necessary for the medical care of the patient's Injury or Sickness,
- 9) Weak, strained or flat feet, corns, calluses, or toenails;
- 10) Cosmetic surgery, or treatment for congenital anomalies (except as specifically provided), except reconstructive surgery as the result of a covered Injury or Sickness. Correction of a deviated nasal septum is considered cosmetic surgery unless it results from a covered Injury or Sickness;
- 11) Elective surgery and elective treatment;
- 12) Diagnostic or surgical procedures in connection with infertility unless infertility is a result of a covered Injury or Sickness;
- 13) Birth control, including surgical procedures and devices;
- 14) Routine new-born baby care, well-baby nursery and related Physician charges;
- 15) Participation in professional or intercollegiate athletics;
- 16) Injury or Sickness for which benefits are paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation;
- 17) Organ transplants;
- 18) War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered);
- 19) Participation on a riot or civil disorder; commission of or attempt to commit a felony in the country in which it was attempted or committed;
- 20) Suicide or attempted suicide (including drug overdose) while sane or insane (while sane in Missouri); or intentionally self-inflicted Injury;
- 21) Charges of an institution, health service, or infirmary for whose service payment is not required in the absence of insurance;
- 22) Treatment of nervous or mental disorders, except as stated in the Schedule of Benefits, or treatment of alcoholism or drug abuse, except as provided for treatment of mental or nervous disorders, according to the Schedule of Benefits;
- 23) Loss incurred from riding in any aircraft, other than as a passenger in an aircraft licensed for the transportation of passengers;
- 24) Treatment, services, supplies or facilities in a Hospital owned or operated by: a) the Veteran's Administration; or b) a national government or any of its agencies. (This exclusion does not apply to treatment when a charge is made which the Insured is required by law to pay);
- 25) Duplicate services actually provided by both a certified nurse-midwife and Physician;
- 26) Expenses payable under any prior policy which was in force for the person making the claim;
- 27) Expenses incurred during a Hospital emergency room visit which is not of an emergency nature;
- 28) Expenses incurred for outpatient treatment in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column;
- 29) Medical expense resulting from a motor vehicle accident in excess of that which is payable under any valid and collectible insurance;
- 30) Pregnancy expenses or Sickness resulting from pregnancy, childbirth, or miscarriage; or for miscarriage resulting from Injury; or voluntary or elective abortion;
- 31) Expenses covered by any other valid and collectible medical, health or accident insurance;
- 32) Expenses incurred after the date insurance terminates for an Insured Person except as may be specifically provided;
- 33) Expenses incurred for injuries resulting from the use of alcohol or intoxicants, or any drugs unless prescribed by a Physician;
- 34) Sexually transmitted disease, including AIDS.

THERE ARE NO BENEFITS PROVIDED FOR THE FOLLOWING:

Elective Surgery and Elective Treatment: including but is not limited to surgery and/or treatment for acne; acupuncture; allergy; including allergy testing; alopecia; biofeedback-type services; birth control; breast implants; breast reduction; circumcision; corns, calluses and bunions; cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under the policy; family planning; fertility tests; gynecomastia; hirsutism; impotence, organic or otherwise; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; learning disabilities; nasal and sinus surgery; nicotine addiction; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia of any kind); patient controlled anesthesia treatment of a covered Injury; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including testing thereof; temporomandibular joint dysfunction, tubal ligation; vasectomy; and weight reduction. Elective surgery and elective treatment includes any service, treatment; or supplies that: 1) are deemed by the company to be researched or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

Notification and Network Information

While Seven Corners does not have network facilities outside the United States, the quality of medical attention available is important to us. Outside of the United States, the Insured must pre-notify Seven Corners Assist for any hospital admissions or any inpatient / outpatient surgeries.

How to obtain travel assistance

To receive assistance worldwide, call Seven Corners Assist at the numbers below and provide them with your ID Number. For Emergency Medical Evacuation, Return of Remains, Emergency Reunion, Return of Minor Child, Assistance Services, call: if in the United States or Canada: 1-800-690-6295 or if outside the United States or Canada: 1-317-818-2808 (collect)

Claims Services

Important Note: Claim forms and receipts for medical expenses must be sent to Seven Corners quickly. Claim submissions must be made within 90 (ninety) after the Date of Service. Should they be received after 90 (ninety) days, they may be considered ineligible.

To report claims or verify eligibility, send the original bills and claim forms to Seven Corners, Inc. or call or fax to the numbers below. Be certain to include your ID# shown on the ID Card with all correspondences:
Seven Corners

303 Congressional Blvd; Carmel, IN 46032
800-335-0477 or 317-575-2656 FAX 317-575-2256 email: info@sevencorners.com www.sevencorners.com

GENERAL PROVISIONS

ENTIRE CONTRACT CHANGES: The policy, including the endorsements and attached papers, if any, shall constitute the entire contract between the parties. No agent has authority to change the policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed herein or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date. All statements made by the Policyholder will, in the absence of fraud, be deemed representations and not warranties.

NOTICE OF CLAIM: Written notice of claim must be given to the company within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Company or its authorized representatives with information sufficient to identify the claimant shall be deemed notice to the Company.

CLAIM FORMS: Upon receipt of a notice of claim, the Company will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Benefits payable under the policy for any loss other than for loss which the policy provides any periodic payment will be paid immediately upon the Company's receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which the policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

PAYMENT OF CLAIMS: Upon receipt of due written proof of death, payment for loss of life of an Insured will be made in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such beneficiary designation is effective, payment will be made to the Insured's estate. If an Insured dies before all payments due have been made, the amount still payable will be paid, at the option of the Company, either to such beneficiary or to such estate.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured suffering the loss.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding \$1,000 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

PHYSICAL EXAMINATION AND AUTOPSY: The Company at its own expense has the right and opportunity to examine the person of any individual whose loss is the basis of claim under the policy when and as often as it may reasonably require during the pendency of the claim and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on the policy prior to the expiration to 60 days after written proofs of loss have been furnished in accordance with the requirements of the policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

SUBROGATION: The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for Benefits made by the company for benefit of an Insured Person. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

RIGHT OF RECOVERY: Payments made by the company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations who are obligated in respect of any covered Injury or Sickness and their liability may appear.

MORE THAN ONE POLICY: Insurance effective at any one time on the Insured person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

CONFORMITY WITH STATE STATUTES: Any provision of the policy which, on its effective date, is in conflict with the statutes of the state in which it was delivered or issued, is hereby amended to conform to the minimum requirements of such statutes.

INCONTESTABILITY. The validity of the policy will not be contested after it has been in force for two year(s) from the Policy Effective Date, except as to nonpayment of premiums.

ASSIGNMENT. The policy is non-assignable. An Insured may not assign any of his or her rights, privileges or benefits under the policy.

MISSTATEMENT OF AGE. If premiums for the Insured are based on age and the Insured has misstated his or her age, there will be a fair adjustment of premiums based on his or her true age. If the benefits for which the Insured is insured are based on age and the Insured has misstated his or her age, there will be an adjustment of said benefit based on his or her true age. The Company may require satisfactory proof of age before paying any claim.

WORKERS' COMPENSATION. The policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.