

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 Policyholder named in the Declarations (herein called Policyholder) 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.

InboundSM Immigrant

This document is a Program Summary outlining the full description in the Inbound Immigrant Policy, Number GLB-9113361-B

Administrator

Seven Corners, Inc.

303 Congressional Blvd., Carmel, IN 46032

Seven Corners Claims Office

800-335-0477 or 317-575-2656

Fax 317-575-2256 – claims@sevencorners.com

Seven Corners Assist

800-690-6295 or 317-818-2808

Fax 317-815-5984 – assist@sevencorners.com

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.

ELIGIBILITY

Persons who are non-US citizens, over the age of 14 days who are traveling to the United States for business, pleasure, to study or to immigrate, who have arrived in the United States within the 24 months prior to the proposed Effective Date, who have paid premium as outlined in the enrollment application, and who have completed the enrollment form in complete detail are eligible for Inbound Immigrant. The Company maintains its right to investigate to verify that the eligibility requirements have been met. If and whenever the Company discovers that the policy 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 Named Insured'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 31st day of any Insured Person's return trip to his or her Home Country whether days of the trip are consecutive or not; or
3. 60 months after the Named Insured's original effective date; or
4. The date the Named Insured becomes a United States citizen; or
5. The date of entry into active duty military service; or
6. 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);
7. 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

"COVERED MEDICAL EXPENSES" means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) 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 otherwise payable as Covered Medical Expenses before payment of any benefit is made. 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.

“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.

“NEWBORN INFANT” means any child born of an Insured while that person is insured under the policy. Newborn Infants will be covered under the policy for the first 31 days after birth ONLY IF the Newborn Infant’s mother was both a) insured under the policy when the Newborn Infant was born and b) her pregnancy was a covered condition under the policy. Coverage for such child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child’s parent. The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue coverage the Insured must, within the 31 days after the child’s birth: 1) apply to us; and 2) pay the required additional premium for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child’s birth.

“PHYSICIAN” means a person, other than the Insured or a member of the Insured’s family, who holds a medical license or medical certificate.

“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.

“USUAL AND CUSTOMARY CHARGES” means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Provider. No payment will be made under the policy for any expenses incurred which in the judgement of the Company are in excess of Usual and Customary Charges.

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) or \$100,000 (Plan B)
 Age 70 and over: \$50,000

Deductible Per Person Per Sickness or Injury:

Ages 14 days through 69: Option \$75 or \$150
 Age 70 and over: Option \$125 or \$250

No Coinsurance applies.

	Plan A	Plan B	Age 70 and Over
INPATIENT	\$50,000 Max per injury/sickness	\$100,000 Max per injury/sickness	\$50,000 Max per injury/sickness
Hospital Room & Board including Laboratory Tests, X-Rays, Prescription Medical and other miscellaneous	Up to \$1725/day, 30 day max	Up to \$2400 per day, 30 day max	Up to \$1250/day, 30 day max
Hospital Intensive Care Unit	Additional \$725 /day, 8 day max	Additional \$1025/day, 8 day max	Additional \$525/day, 8 day max
Surgical Treatment	Up to \$4200	Up to \$6950	Up to \$3350
Anesthetist	Up to \$1000	Up to \$1650	Up to \$800
Assistant Surgeon	Up to \$1000	Up to \$1650	Up to \$800
Physician's Non-Surgical Visits	Up to \$75/visit, 1/day, 30 visits	Up to \$100/visit, 1/day, 30 visits	Up to \$65/visit, 1/day, 30 visits
Consultant Physician, when requested by attending Physician	Up to \$500	Up to \$575	Up to \$450
Pre-Admission Tests w/in 7 days before Hospital admission	Up to \$1300	Up to \$1300	Up to \$900
Private Duty Nurse	Up to \$650	Up to \$650	Up to \$650
OUTPATIENT			
Surgical Treatment	Up to \$4200	Up to \$6950	Up to \$3350
Anesthetist	Up to \$1000	Up to \$1650	Up to \$800
Assistant Surgeon	Up to \$1000	Up to \$1650	Up to \$800
Physician's Non-Surgical Visits	Up to \$75/visit, 1/day, 10 visits	Up to \$100/visit, 1/day, 10 visits	Up to \$65/visit, 1/day, 10 visits
Diagnostic X-rays & Lab Services	Up to \$500	Up to \$575	Up to \$450
	Additional \$325 - One Cat scan, PET scan or MRI	Additional \$975 - One Cat scan, PET scan or MRI	Additional \$325 - One Cat scan, PET scan or MRI
Hospital Emergency Room	75% of U&C to \$400	75% of U&C to \$650	75% of U&C to \$325
Prescription Drugs	Up to \$135	Up to \$200	Up to \$100
Day surgery miscellaneous, related to outpatient scheduled surgery performed at a Hospital or licensed outpatient surgery center; including the cost of operating room, anesthesia, drugs and medicines and medical supplies.	Up to \$1200	Up to \$1400	Up to \$1050
OTHERS			
Ambulance Services	Up to \$500	Up to \$500	Up to \$500
Initial Orthopedic Prosthesis/brace	Up to \$1325	Up to \$1600	Up to \$1000
Chemotherapy and/or radiation therapy	Up to \$1325	Up to \$1600	Up to \$1000
Dental Treatment for Injury to Sound, Natural Teeth	Up to \$650	Up to \$650	Up to \$650
Mental & Nervous Disorder & Substance Abuse	Same as any Sickness	Same as any Sickness	Same as any Sickness
Maternity (conception occurs at least 90 days after your effective date)	Up to \$2,800	Up to \$2,800	N/A
Physiotherapy	Up to \$45/visit, 1/day, 12 visits	Up to \$45/visit, 1/day, 12 visits	Up to \$45/visit, 1/day, 12 visits
Emergency Evacuation	\$10,000	\$10,000	\$10,000
Repatriation of Remains	\$7,500	\$7,500	\$7,500
AD&D Principal Sum	\$25,000 Common Carrier	\$25,000 Common Carrier	\$25,000 Common Carrier

EMERGENCY EVACUATION AND REPATRIATION OF REMAINS (PART B)

BENEFIT

Emergency Evacuation
 Repatriation of Remains

MAXIMUM AMOUNT

\$10,000 maximum benefit
 \$7,500 maximum benefit

COMMON CARRIER ACCIDENTAL DEATH & DISMEMBERMENT (PART C)

BENEFIT

Accidental Death & Dismemberment

PRINCIPAL SUM

\$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 for the Usual and Customary Charges 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) 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 will pay benefits for covered expenses incurred up to a maximum of \$10,000.00 if an Injury or Sickness commencing during the period of coverage results in the necessary emergency evacuation 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 Evacuation means:

- a) the Insured Person's medical condition warrants immediate transportation from the place where the Insured Person is injured or sick to the nearest Hospital where appropriate 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 are 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. AIU 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 AIU 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 AIU 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 to return the Insured Person's body to the Insured Person's Home Country if he or she dies, not to exceed the maximum of \$7,500.00. Benefits are subject to the Excess Provision. AIU 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 AIU Assist in advance. Covered expenses include, but are not limited to, expenses for embalming, cremation, coffins and transportation.

D. HOME COUNTRY COVERAGE

Incidental Trips to Your Home Country: This benefit covers the Insured Person for incidental trips to his or her Home country (30 days per 12 months of purchased coverage or pro rata thereof – example: approximately 2½ days per month of purchased coverage). Maximum benefit is reduced to \$50,000 for any illness or injury occurring while on an incidental trip to the Home Country.

E. INTERNATIONAL TRAVEL COVERAGE

An insured person may travel to additional countries, other than the United States, up to a maximum of 30 days. You must purchase a minimum of 1 month of coverage. International travel coverage does not include travel back to the insured person's home country, and it does not extend after your current expiration date. International travel must be utilized during your current Period of Coverage.

F. 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.

For Loss of:

	Indemnity
Life.....	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
Either Hand or Foot and Sight of One Eye	Principal Sum
Either Hand or Foot	One-Half the Principal Sum
Sight of One Eye.....	One-Half the Principal Sum

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.

G. 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.

H. 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 INBOUND IMMIGRANT

An Eligible Person may enroll for periods 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. Initial enrollment must occur within 24 months of an Eligible Person's arrival in the United States.

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 60 months.

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) Maximum benefit is reduced to \$50,000 for any illness or injury occurring while on an incidental trip to the Insured Person's Home Country;
- 4) Routine physical, inoculations or other examinations where there are no objective indications of impairment of normal health, or well baby care;
- 5) 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;
- 6) 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;
- 7) Dental treatment, except as the result of Injury to Sound, Natural Teeth as stated in the Schedule of Benefits;
- 8) Professional services rendered by a member of the Insured Person's immediate family, or anyone who lives with the Insured Person;
- 9) Services or supplies not necessary for the medical care of the patient's Injury or Sickness,
- 10) Weak, strained or flat feet, corns, calluses, or toenails;
- 11) 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;
- 12) Elective surgery and elective treatment;
- 13) Diagnostic or surgical procedures in connection with infertility unless infertility is a result of a covered Injury or Sickness;
- 14) Birth control, including surgical procedures and devices;
- 15) Routine new-born baby care, well-baby nursery and related Physician charges;
- 16) Participation in professional or intercollegiate athletics;
- 17) Injury or Sickness for which benefits are paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation;
- 18) Organ transplants;
- 19) 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);
- 20) 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;
- 21) Suicide or attempted suicide (including drug overdose) while sane or insane (while sane in Missouri); or intentionally self-inflicted Injury;
- 22) Charges of an institution, health service, or infirmary for whose service payment is not required in the absence of insurance;
- 23) 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;
- 24) Loss incurred from riding in any aircraft, other than as a passenger in an aircraft licensed for the transportation of passengers;
- 25) 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);
- 26) Duplicate services actually provided by both a certified nurse-midwife and Physician;
- 27) Expenses payable under any prior policy which was in force for the person making the claim;
- 28) Expenses incurred during a Hospital emergency room visit which is not of an emergency nature;
- 29) 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;
- 30) Medical expense resulting from a motor vehicle accident in excess of that which is payable under any valid and collectible insurance;
- 31) Voluntary or elective abortion;
- 32) Expenses covered by any other valid and collectible medical, health or accident insurance;
- 33) Expenses incurred after the date insurance terminates for an Insured Person except as may be specifically provided;
- 34) Expenses incurred for injuries resulting from the use of alcohol or intoxicants, or any drugs unless prescribed by a Physician;
- 35) 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 addition; 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.

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