

Liaison® Majestic Program Summary

Administered By:
Seven Corners, Inc.
303 Congressional Blvd.
Carmel, IN 46032 USA

Quick Contacts

Hospital and Doctor Network in the U.S. - To locate a network facility in the United States, search online at www.sevencorners.com/ppo or contact Seven Corners Assist at 800-690-6295. Advise Seven Corners Assist once you have established an appointment. Use of the network does not guarantee benefits. Please see Pre-Notification / Referral section for additional details and requirements.

Claims – It is important to submit your claims to Seven Corners quickly. To be considered, all claims must be submitted to the Seven Corners Claim Department within 90 days after the date of service.

The Company hereby insures all persons whose Application has been accepted by the Administrator, Seven Corners, on behalf of the Company and whose name is identified on the ID Card, subject to all of the exclusions, limitations and provisions as set forth herein and in the Master Policy of insurance issued by the Company. Coverage is afforded only with respect to the person, coverage, amounts and limits specified herein and as identified on the ID Card for the insurance requested on such Application and for which specified premium has been paid to the Administrator.

PART I - INDIVIDUAL INSURANCE PROVISIONS

Eligibility

Liaison® Majestic provides coverage for individuals and their dependents while traveling outside of their home country. Dependents are considered to be the Primary Insured Person's spouse and natural or legally adopted unmarried children over fourteen (14) days and under nineteen (19) years of age. Home Country is defined as - The country where an Eligible Participant(s) has his/her true, fixed and permanent home and principal establishment.

Effective Date of Individual Insurance

Your coverage will begin on the latest of the following: 1) The moment you depart your Home Country; or 2) The date and time the Application and full plan cost is received and accepted by Seven Corners; or 3) The date requested on the Application

Termination Date of Individual Insurance

Individual coverage will end on the earlier of the following: 1) Your return to your Home Country (except as provided under Home Country Coverage); or 2) The date shown on the ID Card, for which premium has been paid; 3) The date you are no longer eligible under this Policy; 4) When the maximum benefit amount has been paid.

Continuing Coverage (when applicable)

For those who are intending longer international trips, an option is available to you. Seven Corners will email you a renewal notice prior to your program's expiration date. You may complete the renewal process at [_____](#) on the worldwide web.

While a new period of coverage will be issued, your original effective date will be used with regards to calculating your deductible and coinsurance (for up to a total of twelve (12) months, then both will begin again), as well as determining any Pre-existing Conditions.

The maximum period of time Seven Corners will offer this feature is three years (one year for persons age 65 and over). It is important to note that rates and benefits may change for each subsequent period of coverage. A \$5.00 Administrative Fee will be included on each renewal notice. This option is not available if you allow coverage to expire. If this happens, an entirely new program must be purchased (*Pre-existing Condition(s) look back will begin again*).

Home Country Coverage

Incidental Trips to Your Home Country: This benefit covers you for incidental trips to your Home Country (Maximum 60 days per 12 months of purchased coverage or pro rata thereof - example: approximately 5 days per month of purchased coverage, not available for purchases less than 30 days). You must first depart your Home Country in order to utilize this benefit and it does not apply to the final trip home. In the event of a claim, you may be required to provide proof of your travel intentions. Earned Home Country Coverage days for the current Policy year do not extend or carry over after a completed 12 month Period of Coverage. If you choose to renew beyond a 12 month Period of Coverage, the earning of incidental days will start over again, i.e. 5 days for every month that you purchase, allowing up to a maximum amount of 60 days per 12 month Period of Coverage.

Maximum benefit is reduced to **\$50,000** for any Illness or Injury occurring while on an incidental trip to your Home Country. **Follow Me Home Coverage:** This Policy shall pay for Covered Expenses incurred in your Home Country up to **\$5,000** for conditions that are first diagnosed and treated outside Your Home Country (Does not apply for Emergency Medical Evacuation or Repatriation).

Refund of Premium

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.

PART II - DESCRIPTION OF BENEFITS

SCHEDULE OF BENEFITS

<i>All coverages and plan costs listed in this Evidence of Benefits are in U.S. Dollar amounts.</i>	
Medical Maximums	\$60,000; \$125,000; \$600,000; \$1,000,000 Medical Maximum is per person per Period of Coverage. Insureds age 65 to 79 traveling inside the United States are limited to a \$60,000 medical maximum. Insureds age 80 years and older traveling inside the United States are limited to a \$20,000 medical maximum. Insureds age 70 to 79 traveling outside the United States are limited up to a \$125,000 medical maximum. Insureds age 80 years and older traveling outside the United States are limited to a \$20,000 medical maximum.
Deductible	\$0, \$100, \$250, \$500, \$1,000, \$2,500. Deductible is per person per Period of Coverage. Maximum of 3 Policy Period Deductibles per family.
Coinsurance	Individuals traveling outside the U.S. & Canada: After You pay the Deductible, the Policy pays 100% to the selected Medical Maximum. Individuals traveling inside the U.S. & Canada: After You pay the Deductible, the Policy pays 80% of the next \$5,000 of eligible expenses, then 100% to the selected Medical Maximum.
Hospital Indemnity	\$150 per night, up to a maximum of 30 days (Applicable to Individuals traveling outside the U.S. and Canada only)
Dental (Sudden Relief of Pain)	To a maximum of \$100 (Only available to programs purchased for 1 month or more.)

Dental (Accident Coverage)	To a maximum of \$500 (Only available to programs purchased for 1 month or more.)
Emergency Medical Evacuation/Repatriation	\$300,000 (in addition to the Medical Maximum)
Return of Mortal Remains	\$50,000
Political Evacuation:	\$50,000
Felonious Assault	\$10,000
Coma Benefit	\$50,000
Terrorism	Usual, reasonable and customary to \$50,000 Lifetime Maximum
Return of Minor Child(ren)	\$50,000
Emergency Reunion	\$50,000
Local Ambulance Benefit	\$5,000
Accidental Death & Dismemberment (AD&D) <i>Note: In the event of a Common Carrier Accidental Death, this benefit will not be paid.</i>	\$25,000 principal sum for Insured or Insured Spouse \$5,000 principal sum for Dependent Child(ren) Aggregate limit of \$250,000 per family
Common Carrier Accidental Death	\$50,000 principal sum for Insured or Insured Spouse \$12,500 principal sum for Dependent Child(ren) Aggregate limit of \$250,000 per family
Loss of Baggage	\$250
Interruption of Trip	\$5,000
Home Country Coverage	<i>Incidental Trips to The Home Country:</i> Up to \$50,000 <i>Extension of Benefits (Follow Me Home Coverage):</i> Up to \$5,000
Hospital Room & Board	Usual, reasonable and customary to the selected Medical Maximum
Intensive Care	Usual, reasonable and customary to the selected Medical Maximum
Outpatient Medical Expenses	Usual, reasonable and customary to the selected Medical Maximum
Waiver of Pre-existing Conditions	Available only for U.S. citizens traveling outside the United States and Canada. If the insured has a Primary Health Plan as defined herein, the benefit covers to the medical maximum (for persons age 65 and over, the amount is limited to \$2,500). If the insured does not have a Primary Health Plan, the benefit covers the first \$20,000 in eligible medical expenses (for persons age 65 and over, the amount is limited to \$2,500)
Heart Attack and Stroke	Up to \$200 per day for each night spent in the hospital after being admitted for either a heart attack or stroke. (For foreign nationals visiting the United States only)
Benefit Period	180 Days

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

The Company shall pay an indemnity determined from the Table if an Insured Person sustains a Loss stated therein resulting from Injury and subject to the limitations contained in PART IV - EXCLUSIONS, provided that: (a) such Loss occurs within 365 days after the date of Accident causing such Loss; and (b) the indemnity payable for any such Loss shall be the Principal Sum stated on the ID Card, as applicable to such Insured Person and this Insurance; and (c) if more than one Loss stated in said Table of Losses is sustained as the result of one Accident, only one of the amounts, the largest, shall be payable.

For Loss of:	Insured or Spouse	Each Child	
Loss of Life	Principal Sum	\$5,000	
Loss of two Members	Principal Sum	\$5,000	
Loss of one Member	50% of Principal Sum	\$2,500	
Quadriplegia	Principal Sum	\$5,000	(total paralysis of both upper and lower limbs)
Paraplegia	75% of the Principal Sum	\$3,750	(total paralysis of both lower limbs)
Hemiplegia	50% the Principal Sum	\$2,500	(total paralysis of both upper & lower limbs of one side of the body)
Uniplegia	25% of the Principal Sum	\$1,250	(total paralysis of one limb)

The term "Loss", in reference to quadriplegia, paraplegia, hemiplegia and uniplegia, shall mean the complete and irreversible paralysis of such limbs and with regard to hands and feet, actual severance through or above the wrist or ankle joints, and with regard to eyes, entire irrecoverable Loss of sight. The term "Principal Sum" as used herein shall mean the amount stated on the ID Card. "Member" means hand, foot or eye. Only one amount, the largest to which you are entitled is payable for all losses resulting from one accident. In the event of a Common Carrier Accidental Death benefits will be paid once at the higher amount as specified in the schedule of benefits for Common Carrier Accidental Death.

Common Carrier Benefit

Benefits will be paid to you as per the schedule of benefits if you sustain an Accidental Death. Death must occur during the period of coverage while the Insured Person is riding as a passenger (but not a pilot, operator or member of the crew) in or on a Common Carrier.

MEDICAL EXPENSE BENEFITS

Coinsurance

If the Insured Person is traveling inside the United States and Canada: When a covered Injury or Illness is incurred by the Insured Person, the Company will pay 80% of the first \$5,000 of Reasonable and Customary medical charges for Covered Expenses, excess of the Policy Period Deductible as stated on the ID Card. Thereafter, the Company will pay 100% of Reasonable and Customary medical charges for Covered Expenses up to the medical maximum as stated on the ID Card. In no event shall the Company's maximum liability exceed the medical maximum as stated on the ID Card. The Deductible and Coinsurance amount consists of Covered Expenses which would otherwise be payable under this Policy. These expenses must be borne by each Insured Person. A maximum of 3 Policy Period deductibles per family under the same application will apply.

If the Insured Person is traveling outside the United States and Canada: the Company will pay 100% of Reasonable and Customary medical charges for Covered Expenses, excess of the Policy Period Deductible as stated on the ID Card, up to the medical maximum as stated on the ID Card. In no event shall the Company's maximum liability exceed the medical maximum as stated on the ID Card. The Deductible and Coinsurance amount consists of Covered Expenses which would otherwise be payable under this Policy. These expenses must be borne by each Insured Person. A maximum of 3 Policy Period deductibles per family under the same application will apply.

Only such expenses, incurred as the result of and within one hundred and eighty (180) days from a Disablement, which are specifically enumerated in the following list of charges, and which are not excluded in PART IV - EXCLUSIONS, shall be considered as Covered Expenses:

1. Charges made by a Hospital for room and board, floor nursing and other services inclusive of charges for professional service and (with the exception of personal services of a non-medical nature); provided, however, that expenses do not exceed the Hospital's average charge for semi-private room and board accommodations, charges made for an operating room.
2. Charges made for Intensive Care or Coronary Care charges and nursing services.
3. Charges made for diagnosis, treatment and Surgery by a Physician; charges made for the cost and administration of anesthetics.
4. Charges made for Outpatient treatment, same as any other treatment covered on an Inpatient basis. This includes ambulatory Surgical centers, Physicians' Outpatient visits/examinations, clinic care, and Surgical opinion consultations.
5. Charges for medication, x-ray services, laboratory tests and services, the use of radium and radioactive isotopes, oxygen, blood transfusions, iron lungs, and medical treatment; dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.
6. Charges for physiotherapy, if recommended by a Physician for the treatment of a specific Disablement and administered by a licensed physiotherapist.
7. Ground ambulance (within the metropolitan area, up to a \$5,000 maximum) to and from the nearest Hospital with facilities for required treatment. If the Insured Person is in a rural area, then licensed ground ambulance transportation to the nearest metropolitan area shall be considered a Covered Expense.
8. Hotel room charge, when the Insured Person, otherwise necessarily confined in a Hospital, shall be under the care of a duly qualified Physician in a hotel room owing to unavailability of a Hospital room by reason of capacity or distance or to any other circumstances beyond control of the Insured Person.
9. Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items.

The charges enumerated herein shall in no event include any amount of such charges which are in excess of Reasonable and Customary charges. If the charge incurred is in excess of such average charge, such excess amount shall not be recognized as a Covered Expense. All charges shall be deemed to be incurred on the date such services or supplies which give rise to the expense or charge are rendered or obtained.

PreNotification / Referral – Seven Corners Assist must be contacted prior to: (1) any medical treatment being received in the United States; or (2) hospital admissions worldwide; or (3) inpatient or outpatient surgeries worldwide. Additionally, the Company's appointed network provider must be utilized for medical expenses incurred inside the United States (when available – contact Seven Corners Assist with questions). A listing of network facilities can be found at www.sevencorners.com/findproviders on the world wide web. Pre-notification does not guarantee that benefits will be paid. Failure to follow Pre-Notification / Referral will result in a 20% reduction of Eligible Benefits. (For Emergency admissions and situations, Seven Corners Assist must be contacted within 48 hours, or as soon as reasonably possible.)

COMA BENEFIT

Maximum Benefit Amount: \$50,000

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.

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.

HOSPITAL INDEMNITY

Should the Insured Person be hospitalized while traveling outside the United States or Canada, and the hospitalization is considered a Covered Expense, the Company will indemnify the Insured \$150 for each night spent in the hospital up to a maximum of 30 days. This benefit is in addition to any other covered expenses of the program.

EMERGENCY MEDICAL EVACUATION/REPATRIATION

Maximum Benefit Amount: \$300,000

The Company shall pay benefits for Covered Expenses incurred up to \$300,000, if any covered Injury or Illness commencing during the Period of Coverage results in the Medically Necessary Emergency Medical Evacuation or Repatriation of the Insured Person. The Emergency Medical Evacuation or Repatriation must be ordered by the Assistance Company in consultation with the Insured Person's local attending Physician.

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 adequate medical facility where medical treatment can be obtained; or (b) after being treated at a local medical facility as a result of a Emergency Medical Evacuation, the Insured Person's medical condition warrants transportation with a qualified medical attendant to his/her Home Country to obtain further medical treatment or to recover; or (c) both (a) and (b) above. All transportation arrangements must be by the most direct and economical route.

REPATRIATION OF REMAINS

Maximum Benefit Amount: \$50,000

The Company will pay the reasonable Covered Expenses incurred up to \$50,000, to return the Insured Person's remains to his/her then Home Country, if he or she dies. Covered Expenses include, but are not limited to, cremation, expenses for embalming, a minimally necessary container appropriate for transportation, shipping costs, and the necessary government authorizations.

POLITICAL EVACUATION AND REPATRIATION OF REMAINS

Maximum Benefit Amount: \$50,000

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 \$50,000. 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 assistance services provider.

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.

The Political Evacuation and Repatriation of Remains Benefit will not pay, should the Insured not heed Travel Warnings issued by the State Department or the appropriate authorities recommending that travelers avoid a certain country.

EMERGENCY MEDICAL REUNION

Maximum Benefit Amount: \$50,000

When Emergency Medical Evacuation or Repatriation occurs, the Company will arrange and pay, up to \$50,000, 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 \$50,000. (3) The period of Emergency Medical Reunion is not to exceed 10 days, including travel.

RETURN OF MINOR CHILD(REN)

Maximum Benefit Amount: \$50,000

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 \$50,000, 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.

INTERRUPTION OF TRIP

Maximum Benefit Amount: \$5,000

If the Insured is unable to continue the Trip due to the death of a parent, spouse, sibling or child; or due to serious damage to the Insured's principal residence from fire, flood or similar natural disaster (tornado, earthquake, hurricane, etc.), the program will reimburse (up to \$5,000) the Insured for the cost of economy travel, less the value of applied credit from an unused return travel ticket, to return home to their area of principal residence.

LOSS OF CHECKED LUGGAGE

Maximum Benefit Amount: \$250

If the Insured's checked luggage is permanently lost by the airline, the program will reimburse the Insured for the replacement of clothing and personal hygiene items lost to a maximum per article limit of \$50. This benefit is secondary to any other (including airline) coverage available. The Insured must furnish proof to the Company that full reimbursement has been obtained from the airline. This policy will reimburse the Insured up to a maximum benefit of \$250.

DENTAL - EMERGENCY ONLY*

Emergency Dental treatment necessary to resolve acute, spontaneous and unexpected inception of pain to sound natural teeth (up to a maximum of \$100) or Dental treatment necessary to restore or replace sound natural teeth lost or damaged in an Accident which is covered under the program (up to a maximum of \$500). The Deductible and Coinsurance amounts apply to the dental benefit. *Only available to programs purchased for 1 month or more.

NOTE: In the event of an Emergency Medical Evacuation/Repatriation, Return of Mortal Remains, Emergency Medical Reunion, Return of Minor Child(ren), or Interruption of Trip- benefit is needed, arrangements must be made by the Assistance Company. **Failure to utilize the Assistance Company (Seven Corners Assist) for these benefits will void any payment by the Company.** Complete details about required notification of the Assistance Company are listed below.

TERRORISM

Maximum Benefit Amount: \$50,000

Coverage for Injuries and Illnesses resulting from an Act of Terrorism, subject to a \$50,000 Lifetime Maximum, provided all of the following conditions are met:

1. You have no direct or indirect involvement in the Act of Terrorism.
2. The Act of Terrorism is not in a country or location where the United States government has issued a travel warning that has been in effect within the six (6) months prior to your date of arrival.
3. You have not unreasonably failed or refused to depart a country or location following the date a warning to leave that country or location is issued by the United States government.

An Act of Terrorism is defined as: an act, including but not limited to, the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s) committed for political, religious, ideological, or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

WAIVER OF PRE-EXISTING CONDITION

If the Insured is a United States citizen and the United States is his/her Home Country, pre-existing conditions are waived for Eligible Benefits incurred outside the United States and Canada as defined below:

1. For persons less than age 65 with a Primary Health Plan as defined herein, pre-existing conditions are waived up to the medical maximum selected.
2. For persons less than age 65 with no Primary Health Plan as defined herein, pre-existing conditions are waived up to the first \$20,000.
3. For persons age 65 and over, pre-existing conditions are waived up to the first \$2,500 regardless of whether there is a Primary Health Plan.

Verification of the Primary Health Plan will be required at time of claim and if the plan in question is not determined to meet the required definition of a Primary Health Plan, pre-existing conditions will be waived up to the first \$20,000 for persons younger than age 65. Please note that this waiver does not include coverage for known, scheduled, required, or expected medical care, drugs, or treatments existent or necessary prior to the effective date of this program.

ASSISTANCE SERVICES

Pre-Trip Assistance - Telephone information about passports, visas; Telephone information about health hazards in remote areas; Telephone information about inoculations; Help in arranging special medical treatment facilities needed while traveling.

Medical Assistance While Traveling - 24-Hour telephone contact for travel medical emergencies, with assistance in locating medical care; Arranging telephone conferences between your attending and home physicians; Arranging second medical opinions in hospital cases; Relaying emergency messages to family and employer during medical emergencies; Guarantee or payment of medical bills using your available financial resources; 24-hour ticketing service to arrange family visits; Arranging Emergency Medical Evacuation from medically underserved areas; Arranging evacuation for catastrophic claims; Arranging medical transportation home after treatment; Arranging escorts and transportation for unaccompanied children; Arranging transfer of medical records; Arranging Repatriation of Remains for deceased travelers; Notify your health insurer of a claim.

General Travel Assistance - 24 hour telephone contact for baggage and other travel problems; Advice on handling losses and delays; Follow-up contact with airlines regarding baggage; Help with lost passports, ticket and documents; Guarantee or payment of emergency expenses using your available financial resources; Arranging shipments of forgotten, lost or stolen items; Relaying emergency messages.

ID Theft Restoration Service - 24/7 toll-free telephone access to highly trained identity theft specialists; Theft Recovery Kit to help determine if identity theft has occurred and provide guidance in restoring good name and credit; Assignment of a personal case manager who will do most of the identity recovery and follow-up work, if identity theft has occurred; Notify the three major credit bureaus, and the Eligible Person's affected creditors, financial institutions, and utility providers of the identity fraud (US Only); Provide assistance with filing a police report; Research and investigate potential damage to Eligible Person's identity

Concierge Services - Restaurant referrals and reservations; Event Ticketing; Ground transportation coordination; Golf tee time reservations and referrals; Wireless device assistance; Latest worldwide weather and ski reports; Floral Services - Coordination of flower delivery for birthdays, anniversaries, holidays and other special occasions; Local activity recommendations.

PART III – POLICY DEFINITIONS

The term "Accident" or "Accidental" shall mean an event, independent of illness or self inflicted means, which is the direct cause of bodily injury to an Insured Person.

An "Act of Terrorism" is defined as: an act, including but not limited to, the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s) committed for political, religious, ideological, or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

The term "Airworthiness Certificate" shall mean the "Standard" Airworthiness Certificate issued by the Federal Aviation Agency of the United States or its foreign equivalent issued by the government authority having jurisdiction over civil aviation in the country of its registry.

The term "Benefit Period" shall mean the one hundred and eighty days (180) following the onset of an Eligible Accident, Injury or Illness in which to receive Medically Necessary Covered Expenses.

The term "Company" shall mean The Insurance Company of the State of Pennsylvania.

The term "Coinsurance" shall mean the percentage amount of eligible Covered Expenses, after the Deductible, which are the responsibilities of the Insured Person and must be paid by the Insured Person. The Coinsurance amount is stated in Section II, Schedule of Benefits, under each stated benefit.

The term "Common Carrier" shall mean any public air conveyance operating under a valid license providing for the transportation of passengers for hire.

The term "Covered Expense" shall mean "Eligible Benefit".

The term "Deductible" shall mean the amount of eligible Covered Expenses which are the responsibility of each Insured Person and must be paid by each Insured Person before benefits under the Policy are payable by the Company.

The term "Disablement" as used with respect to medical expenses shall mean an illness or an Accidental bodily injury necessitating medical treatment by a Physician as defined in this Policy.

The term "Eligible Benefit(s)" shall mean benefits payable by the Company to reimburse expenses which are for Medically Necessary services, supplies, care, or treatment; due to illness or injury; prescribed, performed or ordered by a Physician; Reasonable and Customary charges; incurred while insured under this program and which do not exceed the maximum benefit. If Medicare is the primary payer, Eligible Benefit(s) does not include any charge: 1) By a hospital in excess of the approved amount as determined by Medicare; 2) By a Physician or other provider, in excess of the lesser of the actual billed charges or a Reasonable and Customary Charge; or a. For providers who accept Medicare assignment, the approved amount as determined by Medicare; or b. For providers who do not accept Medicare assignment, the limiting charge as determined by Medicare.

The term "Emergency" shall mean a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if medical attention is not provided within 24 hours.

The term "Experimental / Investigational" means all services or supplies associated with: 1) treatment or diagnostic evaluation which is not generally and widely accepted in the practice of medicine in the United States of America or which does not have evidence of effectiveness documented in peer reviewed articles in medical journals published in the United States. For the treatment or diagnostic evaluation to be considered effective such articles should indicate that it is more effective than others available; or if less effective than other available treatments or diagnostic evaluations, is safer or less costly; 2) A drug which does not have FDA marketing approval; 3) A medical device which does not have FDA marketing approval; or has FDA approval under 21 CFR 807.81, but does not have evidence of effectiveness for the proposed use documented in peer reviewed articles in medical journals published in the United States. For the device to be considered effective, such articles should indicate that it is more effective than other available devices for the proposed use; or if less effective than other available devices, or is safer or less costly. The Company will make the final determination as to whether a service or supply is Experimental/Investigational.

The term "Hospital" as used in this Policy shall mean except as may otherwise be provided, a Hospital (other than an institution for the aged, chronically ill or convalescent, resting or nursing homes) operated pursuant to law for the care and treatment of sick or injured persons with organized facilities for diagnosis and surgery and having 24-hour nursing service and medical supervision.

The term "Home Country" shall mean the country where an Insured Person has his or her true, fixed and permanent home and principal establishment.

The term "Host Country" shall mean any country other than the country where an Insured Person has his or her true, fixed and permanent home and principal establishment.

The term "Illness" wherever used in this Policy shall mean sickness or disease of any kind.

The term "Injury" wherever used in this Policy shall mean bodily injury caused solely and directly by violent, accidental, external, and visible means occurring while this Policy is in force and resulting directly and independently of all other causes in disablement covered by this Policy.

The term "Insured" or "Insured Person" shall mean a person eligible for benefits under the Policy who has applied for coverage and is named on the application and for whom the company has accepted premium.

The term "Intensive Care" shall mean a cardiac care unit or other unit or area of a Hospital which meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

The term "Loss" in reference to quadriplegia, paraplegia, hemiplegia, and uniplegia, shall mean the complete and irreversible paralysis of such limbs and with regard to hands and feet, actual severance through and above the wrist or ankle joints, and with regard to eyes, entire irrecoverable loss of sight.

The term "Medically Necessary" shall mean services and supplies received while insured that are determined by the Company to be: (1) appropriate and necessary for the symptoms, diagnosis, or direct care and treatment of the Insured Person's medical conditions; (2) within the standards the organized medical community deems good medical practice for the Insured Person's condition; (3) not primarily for the convenience of the Insured Person, the Insured Person's Physician or another Service Provider or person; (4) not Experimental/Investigational or unproven, as recognized by the organized medical community, or which are used for any type of research program or protocol; and (5) not excessive in scope, duration, or intensity to provide safe and adequate, and appropriate treatment. For Hospital stays, this means that acute care as an Inpatient is necessary due to the kinds of services the Insured Person is receiving or the severity of the Insured Person's condition, in that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The fact that any particular Physician may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment Medically Necessary or make the charge of a Covered Expense under this Policy.

The term "Mental Illness" shall mean any condition or disease listed in the most recent edition of the International Classification of Diseases as a mental disorder, which clinically significant behavioral or psychological disorder marked by a pronounced deviation from a normal healthy state and associated with a present painful symptom or impairment in one or more important areas of functioning. This disease must not be merely an expectable response to a particular stimulus. Mental Illness does not mean learning disabilities, attitudinal disorders or disciplinary problems.

The term "Outpatient" shall mean an Insured Person who receives care in a Hospital or another institution, including; ambulatory surgical center; convalescent/skilled nursing facility; or Physician's office, for an illness or injury, but who is not confined and is not charged for room and board.

The term "Policy Period" or "Period of Coverage" shall mean the Period of Coverage issued by the Company to the Insured Person, typically beginning with the Effective Date and ending with the Termination Date or the date coverage is renewed by the Company.

The term "Physician" as used in this Policy shall mean 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.

The term "Pre-Existing Condition" as used in this Policy shall mean Any Injury or Illness which meets the following criteria: a) condition(s), including any related conditions, associated complications or consequences, which manifested during the thirty-six (36) months prior to the Effective Date of coverage under this policy; (b) condition(s) including any related conditions, associated complications or consequences, that should have caused a person to seek medical advice, diagnosis, care or treatment during the thirty-six (36) months prior to

the Effective Date of coverage under this Policy; (c) condition(s) including any related conditions, associated complications or consequences, for which medical advice, diagnosis, care or treatment was recommended, received, or noticed during the thirty-six (36) months prior to the Effective Date of coverage under this Policy; (d) the symptoms which occurred thirty-six (36) months prior to the Effective Date of coverage under this policy would have allowed a person trained in medicine to make a diagnosis of the condition, including any associated complications or consequences, producing the symptoms.

The term "Primary Health Plan" is a Group Health Benefit Plan, an individual health benefit plan, or a governmental health plan designed to be the first payor of claims (such as Medicare*) for an Insured Person in effect prior to the effective date of this Policy and continuing as long as this Policy is in effect. Such plans must have coverage limits in excess of \$50,000 per incident or per year to be considered a Primary Plan. *In order for Medicare to be considered as a Primary Health Plan, the policyholder must have parts A, B, and C. Medicare is not considered a Primary Health Plan for the following: 1. Insured Persons who are receiving treatment for end-stage renal disease. 2.) Insured Persons who are entitled to Medicare benefits as disabled persons. 3. Insured Persons who are less than 65 years and are entitled to Medicare for any other reason.

A "Group Health Benefit Plan" means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include: 1. accident-only, credit or disability insurance coverages; 2. specified disease coverage or other limited benefit policies; 3. long-term care, dental care, or vision care coverages; 4. coverage provided by a single service health maintenance organization; 5. insurance coverage issued as a supplement to liability insurance; 6. insurance coverage arising out of a workers' compensation system or similar statutory system; 7. automobile medical payment insurance coverage; 8. jointly managed trusts authorized under 29 U.S.C. Section 141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157; 9. hospital confinement indemnity coverage; or 10. reinsurance contracts issued on a stop-loss, quota share, or similar basis.

PLEASE NOTE: Your Primary Health Plan must be effective at the time of claim. Medicaid and V.A. health plans do not constitute primary health insurance because they are not defined as the first payor of medical claims.

The term "Reasonable and Customary" shall mean the maximum amount that the Company determines is Reasonable and Customary for Covered Expenses the Insured Person receives, up to but not to exceed charges actually billed. The Company's determination considers: (1) amounts charged by other Service Providers for the same or similar service in the locality where received, considering the nature and severity of the bodily Injury or Illness in connection with which such services and supplies are received; (2) any usual medical circumstances requiring additional time, skill or experience; and (3) other factors the Company determines are relevant, including but not limited to, a resource based relative value scale. For a Service Provider who has a reimbursement agreement, the Reasonable and Customary charge is equal to the amount that constitutes payment in full under any reimbursement agreement with the Company.

The term "Relative" shall mean spouse, parent, sibling, child, grandparent, grandchild, step-parent, step-child, step-sibling, in-laws (parent, son, daughter, brother and sister), aunt, uncle, niece, nephew, legal guardian, ward, or cousin of the Insured Person.

The term "Rest Cures" shall mean a treatment, as for nervous disorders, consisting of complete rest, often with special diet, massage, etc., especially at a spa or sanatorium.

The term "Service Provider" shall mean a Hospital, 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.

The term "Surgery" shall mean an invasive diagnostic procedure; or the treatment of Illness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.

The term "Traveling Companion" shall mean spouse, parent, sibling, child, grandparent, grandchild, step-parent, step-child, step-sibling, in-laws (parent son, daughter, brother, or sister), aunt, uncle, niece, nephew, legal guardian, ward, or business partner of the Insured Person.

PART IV – EXCLUSIONS

For **Medical benefits**, this Insurance does not cover:

1. Any Injury or Illness which meets the following criteria: a) condition(s), including any related conditions, associated complications or consequences, which manifested during the thirty-six (36) months prior to the Effective Date of coverage under this policy; (b) condition(s) including any related conditions, associated complications or consequences, that should have caused a person to seek medical advice, diagnosis, care or treatment during the thirty-six (36) months prior to the Effective Date of coverage under this Policy; (c) condition(s) including any related conditions, associated complications or consequences, for which medical advice, diagnosis, care or treatment was recommended, received, or noticed during the thirty-six (36) months prior to the Effective Date of coverage under this Policy; (d) the symptoms which occurred thirty-six (36) months prior to the Effective Date of coverage under this policy would have allowed a person trained in medicine to make a diagnosis of the condition, including any associated complications or consequences, producing the symptoms.

If you are traveling outside the United States and Canada, the period is twelve (12) months instead of thirty-six (36) months.

If you are a United States citizen and the United States is your Home Country, this exclusion is waived for Eligible Benefits incurred outside the United States and Canada as defined below:

- a) For persons less than age 65 with a Primary Health Plan as defined in the policy, Pre-Existing Conditions are waived up to the medical maximum selected.
- b) For persons less than age 65 without a Primary Health Plan as defined in the policy, Pre-Existing Conditions are waived up to the first \$20,000.
- c) For persons age 65 and over, Pre-Existing Conditions are waived up to the first \$2,500 regardless of whether there is a Primary Health Plan.

This waiver does not include coverage for known, scheduled, required, required or expected medical care, drugs, or treatments existent or necessary prior to the effective date of this program.

If you are a non-United States citizen and suffer a Myocardial Infarction or Stroke and are admitted to a Hospital, this exclusion is waived only in order to pay a \$200 per night benefit for each night spent in the Hospital, up to a maximum benefit of \$3,000. The term "Myocardial Infarction" shall require an acute and emergent onset of the condition. The term "Stroke" shall require an acute and emergent onset of the condition.

2. Charges for Treatment(s) of the following Illness(es) or Surgery(ies), which Manifest(ed) themselves or are recommended, or symptoms occur during the first one hundred and eighty (180) days of Coverage hereunder beginning on the initial Effective Date: any condition of the breast; any treatment of all forms of cancer/neoplasm; any condition of the prostate; disorders of the reproductive system; hysterectomy; gall stones or urologic stones (kidney, ureteral, bladder or urethral stones) and any associated complications; any acne diagnosis or acne related condition; asthma; allergies; tonsillectomy; back conditions; adenoidectomy; hemorrhoids; hemorrhoidectomy; hernia, or any Surgery(ies) that is(are) not Emergency in nature, as Emergency is defined hereunder. (*Does not apply to United States citizens traveling outside of the United States and Canada*)
3. Claims not received by Seven Corners within ninety (90) days of the date of service;
4. Charges for treatment which exceed Reasonable and Customary charges; or Charges incurred for Surgeries or treatments which are Investigational, Experimental, or for research purposes; expenses which are nonmedical in nature;
5. Expenses for Vocational, Speech, Recreational or Music Therapy;
6. Expenses which were not recommended, approved and certified as Medically Necessary and reasonable by a Physician;
7. Suicide or any attempt thereof; self-destruction or any attempt thereof; intentionally self-inflicted Injury or Illness;
8. Expenses as a result of or in connection with the commission of a felony or any other criminal or illegal activity as defined by the local governing body;
9. Any consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to, or arising in connection with war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war;

10. Injury sustained while participating in professional, sponsored and/or organized Amateur or Interscholastic Athletics;
11. Routine physicals, inoculations, or other examinations including but not limited to laboratory, diagnostic, or x-ray examinations where there are no objective indications or impairment in normal health;
12. Treatment of the Temporomandibular joint;
13. Services or supplies performed or provided by a Relative of the Insured Person, or anyone who lives with the Insured Person;
14. Treatment and the provision of false teeth or dentures, normal ear tests and the provision of hearing aids, cosmetic or plastic Surgery (including deviated nasal septum), routine dental expenses, eye refractions or eye examinations for the purpose of prescribing corrective lenses for eye glasses or for the fitting thereof, unless caused by Accidental bodily Injury incurred while insured hereunder;
15. Treatment in connection with alcoholism and drug addiction, or use of any drug or narcotic agent; injury sustained while under the influence of or Disablement due wholly or partly to the effects of intoxicating liquor or drugs or narcotic agent, unless administered under the advice of a Physician and said narcotic agent was taken in accordance with the proper dosing as directed by the physician;
16. Any Mental and Nervous disorders or Rest Cures;
17. Congenital abnormalities and conditions arising out of or resulting therefrom;
18. Weight reduction programs or the surgical treatment of obesity;
19. Expenses incurred during a hospital emergency room visit which is not of an emergency nature;
20. Injury sustained while taking part in mountaineering, hang gliding, parachuting, bungee jumping, zip lining, racing by any animal or motor vehicle or motorcycle, snowmobiling, motorcycle/motor scooter riding (*whether as passenger or driver*), scuba diving involving underwater breathing apparatus (unless PADI or NAUI certified), water skiing, snow skiing and snow boarding, luge, motocross, Moto X, skateboarding, and any other sport or athletic activity which is undertaken for thrill seeking and exposes the insured to abnormal or extreme risk of injury and/or is in violation of applicable laws, rules, or regulations. Mountaineering shall mean the sport, hobby or profession of walking, hiking, and climbing either: 1) utilizing harnesses, ropes, crampons, or ice axes; or 2) ascending 4,500 meters or above. Parachuting shall mean an activity involving the breaking of a free fall using a parachute. (**UNLESS HAZARDOUS SPORTS RIDER IS PURCHASED, SEE PROVISION BELOW, AS THIS EXCLUSION IS REPLACED**);
21. Treatment paid for or furnished under any other individual, government, or group policy or charges provided at no cost to the Insured Person;
22. Treatment of venereal or sexually transmitted disease;
23. Sex change operations, or for treatment of sexual dysfunction or sexual inadequacy;
24. Expenses resulting from Acquired Immune Deficiency Syndrome (AIDS), Aids-Related Complex (ARC) or the Human Immunodeficiency Virus (HIV).
25. Pregnancy expenses or illness resulting from pregnancy, childbirth, or miscarriage; or for miscarriage resulting from an Accident;
26. Drug, treatment or procedure that either promotes or prevents conception, or prevents childbirth, including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal thereof;
27. Expenses incurred while the Insured Person is in their Home Country (except after approved Emergency Medical Evacuation / Repatriation or if treatment is a follow-up to a covered disablement during coverage (see Home Country Coverage Benefit) or if the expenses pertain to the Home Country Coverage Benefit);
28. Expenses incurred for which travel was undertaken to seek medical treatment for a condition; or incurred after the Insured Person's physician has limited or restricted travel.
29. Expenses incurred as a result of the Insured's failure to accept or follow a Physician's advice, treatment, or recommended treatment.

With regards to Accidental Death and Dismemberment, Emergency Medical Evacuation/Repatriation, Return of Mortal Remains, Emergency Medical Reunion, and Return of Minor Child, this Insurance does not cover:

1. Suicide or attempt thereof by the Insured Person while sane or self destruction or any attempt thereof by the Insured Person while insane;
2. Disease or sickness of any kind; (only applicable to AD&D)
3. Bacterial infections except pyogenic infection which shall occur through an accidental cut or wound; (only applicable to AD&D)
4. Hernia of any kind; (only applicable to AD&D)
5. Injury sustained while the Insured Person is riding as a pilot, student pilot, operator or crew member, in or on, boarding or alighting, from any type of aircraft;
6. Injury sustained while the Insured Person is riding as a passenger in any aircraft (a) not having a current and valid Airworthy Certificate and (b) not piloted by a person who holds a valid and current certificate of competency for piloting such aircraft;
7. Any consequence, whether proximately or remotely occasioned by, or traceable to, or arising in connection with the following, which shall hereinafter for the purposes of this Exclusion be called the "Incidents":
 - a) war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war.
 - b) mutiny, riot, strike, military or popular uprising insurrection, rebellion, revolution, military or usurped power.
 - c) any act of any person acting on behalf of or in connection with any organization with activities directed towards the overthrow by force of the Government du jure or de facto.
 - d) martial law or state of siege or any events or causes which determine the proclamation or maintenance of martial law or state of siege.

Any consequence happening or arising during the existence of abnormal conditions (whether physical or otherwise), whether proximately or remotely occasioned by, traceable to, or arising in connection with, any of the said Incidents shall be deemed to be consequences for which the Company shall not be liable under this plan except to the extent that the Insured Person shall prove that such consequence happened independently of the existence of such abnormal conditions.
8. Service in the military, naval or air service of any country;
9. Flying in any aircraft being used for or in connection with acrobatic or stunt flying, racing, endurance tests, rocket-propelled aircraft, crop dusting or seeding or spraying, fire fighting, exploration, pipe or power line inspection, any form of hunting or herding, aerial photography, banner towing or any experimental purpose;
10. Being under the influence of alcohol or having taken drugs or narcotics unless prescribed by a legally qualified physician or surgeon;
11. Injury occasioned or occurring while the Insured Person is committing or attempting to commit a felony or to which a contributing cause was the Insured Person being engaged in an illegal occupation;
12. Riding or driving in any kind of competition;
13. Pregnancy, childbirth, miscarriage or abortion;
14. Covered Expenses incurred after the Insured Person's physician has limited or restricted travel; or Covered Expenses incurred as a result of a change in prescribed treatment during, or within the three (3) months prior to the effective date of coverage.

For Interruption of Trip, this insurance does not cover: (1) war or any act of war, whether declared or not; participation in a felony, riot or insurrection; participation in contests of speed; a Pre-existing Condition existing prior to the Insured's departure from their Home Country that has the likelihood of causing death; the Insured Person or Traveling Companion or Traveling Companion's family making changes to personal plans; having business or contractual obligations; being unable to obtain necessary travel documents (passports, visas, etc.); being detained or having property confiscated by customs authorities; carrier caused delays (including bad weather); prohibition or regulatory by any government; default of yacht charter companies; default of the organization from which the Insured Person purchased their trip arrangements.

For Loss of Checked Luggage, this insurance does not cover: animals; automobiles or automobile equipment; boats; motors; motorcycles; other conveyances or their appurtenances (except bicycles while checked as baggage with a Common Carrier); household furniture; eye glasses or contact lenses; artificial teeth or dental bridges; hearing aids; prosthetic limbs; musical instruments; money or securities; tickets or documents; or sporting equipment if loss or damage results from the use thereof.

Hazardous Sport Coverage (when applicable): To cover motorcycle/motor scooter riding (whether as a passenger or a driver), hang gliding, parachuting, bungee jumping, water skiing, snow skiing, snowmobiling, snowboarding, and spelunking. (covered if the required premium has been paid)

Pre Notification / Referral – Seven Corners Assist must be contacted prior to: (1) any medical treatment being received in the United States; or (2) hospital admissions worldwide; or (3) inpatient or outpatient surgeries worldwide. Additionally, the Company's appointed network provider must be utilized for medical expenses incurred inside the United States (when available – contact Seven Corners Assist with questions). A listing of network facilities can be found at _____ on the worldwide web. Pre Notification does not guarantee that benefits will be paid. Failure to follow Pre Notification / Referral will result in a 20% reduction of Eligible Benefits. (For Emergency admissions and situations, Seven Corners Assist must be contacted within 48 hours, or as soon as reasonably possible.)

Please be aware that this is not a general health insurance policy, but an interim travel medical program intended for use while away from your Home Country or Country of Residence. This Policy does not guarantee payment to a facility or individual for medical expenses until the Company determines that it is an eligible expense.

PART V - POLICY PROVISIONS

1. Notice of Claim: Written notice of claim must be given to the Company within ninety (90) days after the occurrence or commencement of any Disablement covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Administrative Offices of the Company, or to any authorized agent of the Company, with information sufficient to identify the Insured Person shall be deemed notice to the Company.
2. Claim Forms: The Company, upon receipt of a notice of claim, 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 fifteen (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 Disablement for which claim is made.
3. Proof of Loss: Written Proof of Loss must be furnished to the Company at its said office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 (ninety) days after the termination of the period for which the Company is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall 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.
4. Time of Payment of Claims: Indemnities payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written Proof of Loss, all accrued indemnities for loss for which the Policy provides periodic payment will be paid at the expiration of each four (4) weeks during the continuance of the period for which the Company is liable, and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.
5. Payment of Claims: Indemnity for loss of life will be payable 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 designation or provision is then effective, such indemnity shall be payable to the estate of the Insured Person. Any other accrued indemnities unpaid at the Insured Person's death may, at the option of the Company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Insured Person. If any indemnity of the Policy shall be payable to the estate of an Insured Person, or to an Insured Person who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding \$1,000, to any Relative by blood or connection by marriage of the Insured Person who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.
Subject to any written direction of the Insured Person all or a portion of any indemnities provided by this Policy on account of Hospital, nursing, medical or Surgical service may, at the Company's option and unless the Insured Person requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the Hospital or person rendering such services, but it is not required that the service be rendered by a particular Hospital or person.
6. Physical Examination and Autopsy: The Company at its own expenses shall have the right and opportunity to examine the person of any individual whose Injury or Illness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.
7. Legal Actions: No actions at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty (60) days after written Proof of Loss has been furnished in accordance with requirements of this Policy. No such action shall be brought after expiration of three (3) years after that time written Proof of Loss is required to be furnished.

Subrogation

To the extent the Company pays for a loss suffered by an Insured, the Company will take over the rights and remedies the Insured had relating to the loss. This is known as subrogation. The Insured must help the Company to preserve its rights against those responsible for the loss. This may involve signing any papers and taking any other steps the Company may require. If the company takes over an Insured's rights, the Insured must sign an appropriate subrogation form supplied by the Company.

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)

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

Insurance Company

This Insurance, under Policy GLB-9498578, is underwritten by The Insurance Company of the State of Pennsylvania, a member of Chartis Insurance, and is rated A "Excellent" by the A.M. Best Company.

Excluded Country List: Coverage is not available for travel to or from the following countries*: Afghanistan, Chechnya, Cuba, Iran, Iraq, Israel (West Bank and Gaza Strip), Pakistan, Somalia. *This list is subject to change, please visit www.sevencorners.com for an up-to-date list.