TOKIO MARINE HCC

Visit USA Healthcare Budget

DESCRIPTION OF COVERAGE

2501151019

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

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

DESCRIPTION OF COVERAGE SUMMARY

This Description of Coverage is a summary of the provisions contained in Master Policy No.191920-2.3. For a complete copy of the Master Policy, please contact Tokio Marine HCC Medical Insurance Services Group.

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

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

IMPORTANT FEATURES OF **YOUR** TRAVEL INSURANCE

CANCELLATION

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

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

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

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

CLAIMS

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

APPEALS AND COMPLAINTS

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

DEFINITIONS

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

PRE-EXISTING CONDITIONS

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

DATA PROTECTION

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

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

RIGHTS OF THIRD PARTIES

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

LAW AND JURISDICTION

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

ARBITRATION

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

TOKIO MARINE HCC - MEDICAL INSURANCE SERVICES GROUP ("MIS GROUP")

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

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

MEMBER ELIGIBILITY

Non-U.S. Citizens who are at least 14 days of age that are traveling outside of their **home countries.** Individuals ages 70 and above must select Plan A. Individuals age 69 and under may select Plan A or Plan B.

CERTIFICATE EFFECTIVE & TERMINATION DATES

CERTIFICATE EFFECTIVE DATE

Insurance hereunder is effective on the later of:

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

CERTIFICATE TERMINATION DATE

Insurance hereunder terminates on the earlier of:

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

Coverage provided under this Master Policy is for a maximum duration of 364 days.

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

SCHEDULE OF BENEFITS AND LIMITS

All benefits, except Emergency Medical Evacuation, Repatriation of Remains, Local Burial or Cremation, and Emergency Reunion, are subject to deductible and are per injury or illness, up to the overall policy maximum, unless stated otherwise.

DEDUCTIBLE		
	Plan A	**Plan B**
Ages 14 days - 69 years	$0, $50, $100, or $250	
Age 70 and above	$100 or $250	
OVERALL POLICY MAXIMUM		
	Plan A	**Plan B**
Ages 14 days - 69 years	$50,000	$150,000
Ages 70-79	$50,000	
Ages 80 and above	$20,000	
INPATIENT TREATMENT		
	Plan A	**Plan B**
Hospital Room &Board, including miscellaneous unless specified	$1,500 per day, 30 days max	$2,750 per day, 30 days max
Intensive Care Unit, including miscellaneous unless specified	$2,500 per day, 8 days max	$4,000 per day, 8 days max

Surgery	$4,000 per session	$8,000 per session
Consultant physician	$450	$650
Private duty nurse	$550	$700
Physician visits	$75 per visit, 30 visits max	$125 per visit, 30 visits max
OUTPATIENT TREATMENT		
	Plan A	**Plan B**
Surgery	$3,300 per session	$7,150 per session
Outpatient Surgical Facility	$1,100	$1,500
Pre-admission Testing	$1,100	$1,450
Diagnostic X-ray and Labs	$500, plus $400 for one CAT Scan, MRI or PET	$750, plus $650 for one CAT Scan, MRI or PET
Emergency Room (all expenses incurred therein)	$375	$785
Observation Room Services (all expenses incurred therein)	$355	$750
Outpatient Prescription Drugs	$150	$300
Office Visits, including Urgent Care	$75 per visit, 10 visits max	$150 per visit, 10 visits max
MISCELLANEOUS INPATIENT & OUTPATIENT TREATMENT		
	Plan A	**Plan B**
Anesthesiologist	$825	$1,775
Assistant Surgeon	$825	$1,775
Local Ambulance	$500	$500
Physical Therapy	$50 per visit, 1 visit per day, maximum 12 visits	
Durable Medical Equipment	$1,100	$1,700
Acute Onset of Pre-existing Conditions	Ages 65 and above: $2,500 All others: $20,000	Ages 65 and above: $2,500 All others: $20,000
	$25,000 Lifetime Maximum for Emergency Medical Evacuation	
Terrorism	Up to $25,000, eligible medical expenses only	
OTHER BENEFITS **Not subject to deductible or overall policy maximum**		
	Plan A	**Plan B**
Emergency Medical Evacuation	$100,000 Lifetime Maximum, except as provided under Acute Onset of Pre-existing Condition.	
Repatriation of Remains	$25,000	
Local Burial & Cremation	$5,000	
Emergency Reunion	$15,000, subject to a maximum of 15 days - *not subject to deductible or coinsurance*	

CLAIM PROCEDURES

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

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

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

PROOF OF CLAIM

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

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

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

CLAIMS COOPERATION

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

ACCESS TO ADDITIONAL MATERIALS

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

OTHER INSURANCE

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

APPEAL AND COMPLAINTS PROCEDURE

APPEALING A CLAIM

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

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

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

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

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

COMPLAINTS PROCEDURE

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

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

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

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

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

Complaints
Lloyd's
One Lime Street
London EC3M 7HA

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

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

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

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

ARBITRATION AND CLASS ACTION WAIVER

Excluding claims for injunctive or other equitable relief, any dispute or controversy between a Member and any of the MIS Group, Underwriters or their affiliates arising out of or relating to this Master Policy, including without limitation, any and all disputes, claims (whether in tort, contract, statutory or otherwise) or disagreements concerning the existence, breach, interpretation, application or termination of this Master Policy, shall be resolved by final and binding arbitration pursuant to the Federal Arbitration Act and in accordance with the JAMS Inc. Comprehensive Arbitration Rules & Procedures then in effect. Such claims shall be arbitrated on an individual basis only and the parties waive any right or authority for any claims to be resolved in a class, consolidated, representative, collective or private attorney general action or arbitration. The arbitration shall take place in [Houston, Texas] or at the option of the party seeking relief, by telephone, online, or via written submissions alone, and be administered by JAMS. The arbitral tribunal ("Tribunal") shall be composed of one arbitrator, who shall be independent and impartial. If the parties fail to agree on the arbitrator within twenty (20) calendar days after the initiation of an arbitration hereunder, JAMS shall appoint the arbitrator. The arbitration shall be conducted in the English language. The decision of the arbitrator will be final and binding on the parties. Judgment on any award(s) rendered by the arbitrator may be entered in any court having jurisdiction thereof. The arbitrator shall have the authority to determine arbitrability of any disputes arising out of or relating to this Master Policy. Nothing in this Section shall prevent either party from seeking immediate injunctive relief from any court of competent jurisdiction, and any such request shall not be deemed incompatible with the agreement to arbitrate or a waiver of the right to arbitrate. The parties undertake to keep confidential all awards in their arbitration, together with all confidential information, all materials in the proceedings created for the purpose of the arbitration and all other documents produced by the other party in the proceedings and not otherwise in the public domain, save and to the extent that disclosure may be required of a party by legal duty, to protect or pursue a legal right or to enforce or challenge an award in legal proceedings before a court or other judicial authority. The arbitrator shall award all fees and expenses, including reasonable attorney's fees, to the prevailing party. This agreement to arbitrate does not apply to claims Members may have for medical malpractice against their medical providers.

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

PRE-EXISTING MEDICAL CONDITIONS

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

Pre-existing Condition means any

1. Condition for which medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) was recommended or received during the 18 months immediately preceding the certificate effective date;
2. Condition that had manifested itself in such a manner that would have caused a reasonably prudent person to seek medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) within the 18 months immediately preceding the certificate effective date; or
3. **Injury**, **illness**, sickness, disease, or other physical, medical, mental, or nervous conditions, disorder or ailment (whether known or unknown) that, with reasonable medical certainty, existed at the time of application or within the 18 months immediately preceding the certificate effective date.

ACUTE ONSET OF PRE-EXISTING CONDITION

YOU ARE COVERED:

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

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

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

YOU ARE NOT COVERED IF:

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

MEDICAL & REPATRIATION EXPENSES

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

INPATIENT BENEFITS

YOU ARE COVERED:

1. Hospital room and board expenses including:
   a. Daily room and board and nursing services not to exceed the amount and duration specified in the Schedule of Benefits and Limits; and
   b. Services, supplies, and other **hospital** miscellaneous which are routinely provided by the **hospital** to persons for use while **inpatient**; and
   c. Diagnostic testing using radiology, ultrasonic or laboratory services (psychometric, intelligence, competency, behavioral and educational testing are not included); and
   d. Care in an **extended care facility** following direct transfer from an acute care **hospital**, provided such care is recommended by the attending **physician** for convalescence related to the **illness** or **injury** for which **you** were hospitalized as **inpatient**. **Extended care facility** benefits accrue toward the limits for Hospital Room and Board.
2. Intensive Care Unit:
   a. Daily room and board and nursing services in **intensive care unit** not to exceed the amount and duration specified in the Schedule of Benefits and Limits; and
   b. Services, supplies, and other **hospital** miscellaneous which are routinely provided by the **hospital** to persons for use while **inpatient**; and
   c. Diagnostic testing using radiology, ultrasonic or laboratory services.
3. Inpatient Surgery: Professional services provided by a **physician**, **specialist physician**, and/or surgeon for diagnosis, treatment, and surgery of a covered condition. All covered expenses relating to an **inpatient surgery**, including **physician** consultations prior to and after **surgery**, will be paid under the **inpatient surgery** benefit.
4. **Inpatient** professional fees for a consultant **physician** when the consultant **physician** has been requested and approved by the attending **physician**.
5. Routine pre-admission testing consisting of major diagnostic procedures, including but not limited to CAT scans, NMR's, and blood chemistries, will be payable under the "Hospital Miscellaneous" benefit.

6. Private duty nursing care while hospitalized as **inpatient**, when ordered by a licensed **physician**, and if **medically necessary**, but not to include general nursing care provided by the **hospital**.
7. **Physician** visits while **you** are hospitalized as **inpatient**, limited to one visit per day and when hospitalization is not related to **surgery**.

YOU ARE NOT COVERED IF:

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

OUTPATIENT BENEFITS

YOU ARE COVERED:

1. Outpatient Surgery: Professional services provided by a **physician**, **specialist physician**, and/or **surgeon** for diagnosis, treatment, and surgery of a covered condition. All covered expenses relating to an **outpatient surgery** will be paid under the Outpatient Surgery benefit unless otherwise covered by the Outpatient Surgical Facility benefit.
2. Outpatient Surgical Facility: Miscellaneous charges, including operating room, laboratory tests and x-ray exams, professional fees, anesthesia, drugs or medicines (but not for take home drugs), therapeutic services and supplies, when related to an **outpatient** surgery covered hereunder.
3. Routine pre-admission testing including but not limited to complete blood count, urinalysis, and chest x-ray completed within seven days prior to the date of **hospital** admission.
4. Diagnostic testing using radiology, ultrasonic or laboratory services other than such services that are related to a covered **outpatient surgery**.
5. Emergency room expenses, including charges for use of the emergency room itself and any supplies or other charges incurred during use of the emergency room for a covered **injury**, even if **hospital** confinement is not required, or for a covered **illness** which results in hospitalization as **inpatient**.
6. Observation room services, when an observation stay (a period not to exceed 48 hours) meets the following conditions:
    a. The patient is clinically unstable for discharge; and
    b. Clinical monitoring, and/or laboratory, radiologic, or other testing is necessary in order to assess the patient's need for hospitalization; or
    c. The treatment plan is not established or, based upon the patient's condition, is anticipated to be completed within a period not to exceed 48 hours; or
    d. Changes in status or condition are anticipated and immediate medical intervention may be required.
7. Changes in status or condition are anticipated and immediate medical intervention may be required.
8. For drugs which require prescription by a **physician** for treatment of a covered **injury** or **illness**, but not for the replacement of lost, stolen, damaged, expired or otherwise compromised drugs, and for a maximum supply of 60 days per prescription.
9. Charges for **physician** and **urgent care center** office visits, including injections administered during visit, for visits not covered under the Outpatient Surgery Benefit.

YOU ARE NOT COVERED IF:

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

INPATIENT OR OUTPATIENT BENEFITS

YOU ARE COVERED:

1. Professional services provided by an anesthesiologist and/or assistant **surgeon** up to 25% each of the **Usual, reasonable and customary** charge of the primary **surgeon**. Standby availability will not be deemed to be a professional service and therefore will not be covered hereunder.
2. Emergency Local Ambulance transport necessarily incurred in connection with **injury** or **illness** resulting in **inpatient** hospitalization.
3. **Medically necessary** rental of **durable medical equipment** (consisting of a standard basic hospital bed and or a standard basic wheelchair) up to the purchase prices.
4. **Physical therapy** if prescribed by a **physician** who is not affiliated with the **physical therapy** practice, necessarily incurred to continue recovery from a covered Injury or Illness.

YOU ARE NOT COVERED IF:

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

EMERGENCY MEDICAL EVACUATION

YOU ARE COVERED:

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

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

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

YOU ARE NOT COVERED IF:

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

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

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

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

REPATRIATION OF REMAINS

YOU ARE COVERED:

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

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

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

YOU ARE NOT COVERED IF:

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

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

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

LOCAL BURIAL OR CREMATION

YOU ARE COVERED:
1. For **you** to be buried or cremated in the country of death in lieu of Repatriation of Remains up to the specified benefit maximum.

YOU ARE NOT COVERED unless **you** fulfill the following conditions:
1. The **illness** or **injury** giving rise to the expense is covered under this insurance; and
2. Travel arrangements are approved in advance and coordinated by **us.**

YOU ARE NOT COVERED IF:
1. The death occurs in **your home country;** or
2. The Emergency Medical Evacuation or Repatriation of Remains benefit is used; or
3. Expenses arise directly or indirectly from anything in the General Exclusions.

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

EMERGENCY REUNION

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

YOU ARE NOT COVERED unless **you** fulfill the following conditions:
1. **You** have a covered Emergency Medical Evacuation.

YOU ARE NOT COVERED IF:
1. Expenses arise directly or indirectly from anything in the General Exclusions.

SPORTS AND ACTIVITIES

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

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

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

YOU ARE NOT COVERED IF:
1. The activity is organized athletics involving regular or scheduled practice and/or games; or
2. The activity is performed in a professional capacity or for any wage, reward, or profit; or
3. Expenses arise directly or indirectly from anything in the General Exclusions; or
4. Any of the excluded items listed below:

- All-Terrain Vehicles
- American Football
- Aussie Rules Football
- Aviation (except when traveling solely as a passenger in a commercial aircraft)
- Base Jumping
- Big Game Hunting or Safari
- Bobsleigh
- Boxing
- Bungee-Jumping
- Cave Diving
- Hang-Gliding
- Heli-Skiing
- Hot Air Ballooning as a Pilot
- Ice Hockey
- Jousting
- Kite-Surfing
- Luge
- Martial Arts
- Modern Pentathlon
- Motorized Dirt Bikes
- Mountaineering
- Outdoor Endurance Events
- Parachuting
- Paragliding
- Powerlifting
- Quad Biking
- Racing by any Animal, Motorized Vehicle, or BMX, and Speed Trials and Speedway
- Rugby
- Running with the Bulls
- Skeleton
- Sky Surfing
- Snow Skiing and Snowboarding
- Snow Mobiles
- Spelunking
- Sub Aqua Pursuits involving underwater breathing apparatus
- Surfing
- Tractors
- Waterskiing
- Whitewater Rafting
- Wrestling

TERRORISM

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

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

YOU ARE NOT COVERED IF:

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

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

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

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

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

GENERAL EXCLUSIONS

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

1. **Pre-existing Conditions**, except charges resulting directly from an Acute Onset of Pre-existing Condition, as herein defined, subject to the limits set forth in the Schedule of Benefits and Limits.
2. Birth defects and congenital illnesses. Birth defects are deemed to include hereditary conditions.
3. Pregnancy, termination of pregnancy, routine prenatal care, child birth, postnatal care, and charges incurred by a child under the age of 14 days.
4. **Mental health disorders**.
5. Impotency or sexual dysfunction.
6. All **sexually transmitted diseases** and conditions.
7. HIV, AIDS, or ARC, and all diseases caused by and/or related to HIV.
8. All forms of cancer / neoplasm.
9. **Substance abuse** or addiction or conditions that may be attributed to **substance abuse** or addictions and direct consequences thereof.
10. Acne, moles, skin tags, diseases of sebaceous glands, seborrhea, sebaceous cyst, hypertrophic and atrophic conditions of skin, nevus.
11. Sleep apnea or other sleep disorders.
12. Obesity or weight modification, including but not limited to wiring of the teeth and all forms of intestinal bypass **surgery**.

13. Self-inflicted **injury** or **illness** and/or suicide or attempted suicide whether sane or insane.
14. **Injury** sustained that is due wholly or partially to the effects of intoxication or drugs other than drugs taken in accordance with treatment prescribed by a **physician** and except drugs prescribed for the treatment of substance abuse.
15. **Injury** sustained while operating any motorized vehicle, aircraft or watercraft whether registered or not while under the influence of alcohol as defined under the law of the jurisdiction where the **injury** occurs or with a .08 Blood Alcohol Content (BAC), whichever is lower.
16. Routine medical examinations, including but not limited to vaccinations, immunizations, annual check-ups, the issue of medical certificates and attestations, and examinations as to the suitability of employment or travel.
17. Dental treatment and treatment of the temporomandibular joint.
18. Promotion or prevention of conception including but not limited to: artificial insemination, treatment for infertility, sterilization or reversal of sterilization.
19. Organ or tissue transplants or related services.
20. Eye **surgery**, such as corrective refractory **surgery**, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
21. Corrective devices and medical appliances, including eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, and any examination or fitting related to these devices, dentures or dental appliances, and all vision and hearing tests and examinations.
22. Orthoptics and visual eye training.
23. Orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses or toenails.
24. Hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed.
25. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinesiotherapy.
26. Psychometric, intelligence, competency, behavioral and educational testing.
27. Cosmetic or aesthetic reasons, except for reconstructive **surgery** when such **surgery** is directly related to and follows a **surgery** which was covered hereunder.
28. Modifications of the physical body intended to improve the psychological, mental or emotional well-being, including but not limited to sex-change **surgery**.
29. Exercise programs, whether or not prescribed or recommended by a **physician**.
30. Incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
31. Cryo preservation and implantation or re-implantation of living cells.
32. Genetic or predictive testing.
33. **Investigational, experimental or for research** purposes.
34. While confined primarily to receive **custodial care, educational or rehabilitative care**, or any medical treatment in any establishment for the care of the aged.
35. Not **medically necessary**.
36. Not administered by or under the supervision of a **physician**, and products that can be purchased without a doctor's prescription.
37. Provided by a **relative**, family member or any person who ordinarily resides with **you**.
38. Provided by **home nursing care**.
39. Provided by a chiropractor.
40. Provided at no cost to **you**.
41. Telephone consultations or failure to keep a scheduled appointment.
42. Payable under any government system, including the Australian Medicare system.
43. Charges exceeding **usual, reasonable and customary.**
44. Charges resulting from or occurring during the commission of a violation of law, including without limitation, the engaging in an illegal occupation or act, but excluding minor traffic violations.

45. Charges resulting from a disease outbreak in a country or location for which the U.S. Centers for Disease Control and Prevention (CDC) has issued a Level 3 Travel Warning if a) the warning has been in effect within the 6 months immediately prior to **your** date of arrival, or b) within 10 days following the date the warning is issued **you** have failed to depart the country or location.
46. War, military action or while on duty as a member of a police or military force unit.
47. Travel or accommodations, except as provided for in the Local Ambulance, Emergency Medical Evacuation, and Repatriation of Remains sections of this insurance.
48. Diagnosis, treatment, services, or supplies provided by Home Nursing Care.
49. Incurred within **your home country.**
50. Incurred outside **your certificate period**.
51. Submitted to **us** for payment more than 60 days after the last day of the **certificate period**.
52. When departure from the **home country** is to obtain treatment in the destination country/countries.
53. Complications or consequences of a treatment or condition not covered hereunder.
54. Not included as Eligible Expenses as described herein.

DEFINITIONS

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

Acute Onset of Pre-existing Condition means a sudden and unexpected outbreak or recurrence of a **pre-existing condition(s)** which occurs spontaneously and without advance warning either in the form of **physician** recommendations or symptoms, is of short duration, is rapidly progressive, and requires urgent care. The Acute Onset of a Pre-existing Condition(s) must occur after the certificate effective date. Treatment must be obtained within 24 hours of the sudden and unexpected outbreak or recurrence. A **pre-existing condition** that is a chronic or congenital condition or that gradually becomes worse over time will not be considered Acute Onset. This benefit does not include coverage for known, scheduled, required, or expected medical care, drugs or treatments existent or necessary prior to the certificate effective date.

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

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

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

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

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

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

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

Emergency means a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing **your** life or limb in danger if medical attention is not provided within 24 hours.

Extended Care Facility means an institution, or a distinct part of an institution, which is licensed as a **hospital**, **extended care facility** or rehabilitation facility by the state in which it operates; and is regularly engaged in

providing 24-hour skilled nursing care under the regular supervision of a **physician** and the direct supervision of a registered nurse; and maintains a daily record on each patient; and provides each patient with a planned program of observation prescribed by a **physician**; and provides each patient with active treatment of an **illness** or **injury**. **Extended care facility** does not include a facility primarily for rest, the aged, **substance abuse** treatment, **custodial care**, nursing care or for care of **mental health disorders** or the mentally incompetent.

Home Country means the country where **you** principally reside and receive regular mail. U.S. Citizens are not eligible for coverage within the U.S., except as provided under home country coverage, regardless of the location of **your** principal residence.

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

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

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

Illness means a sickness, disorder, **illness**, pathology, abnormality, ailment, disease or any other medical, physical or health condition. **Illness** does not include learning disabilities, attitudinal disorders or disciplinary problems.

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

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

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

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

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

Member means an individual who is covered under this insurance.

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

Observation means the use of a bed and periodic monitoring and/or short term treatment by a **hospital's** nursing or other staff. These services are considered reasonable and necessary to evaluate a patient's condition

to determine the need for possible **inpatient** admission. Observation care provides a method of evaluation and treatment as an alternative to **inpatient** hospitalization. The services may be considered eligible for coverage only when provided under a **physician's** order or under the order of another person who is authorized by state statute and the **hospital's** by laws to admit patients and order outpatient testing. The observation services must be patient-specific and not part of a standard operating procedure or facility protocol for a given diagnosis or service.

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

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

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

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

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

Specialist Physician means a doctor of medicine (MD) who has completed the training for and has become certified in a specialty or sub-specialty of the medical arts. Specialist Physician does not include a Doctor of Chiropractic (DC), a Doctor of Psychiatry (PsyD) or Doctor of Psychology (PhD). A **physician** must be currently licensed by the jurisdiction in which the services are provided, and the services must be within the scope of that license.

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

Surgery or Surgical Procedure means an invasive diagnostic procedure or the treatment of **illness** or **injury** by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.

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

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

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

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

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