

Bordercross WorldwideSM Medical Procedure Insurance Policy

Underwritten by: Certain Underwriters at Lloyd's, London

(Herein called the Company)

Certain Underwriters at Lloyd's, London, herein referred to as "the Company" hereby insures all persons whose Application/ Enrollment Form has been Approved, by Seven Corners, Inc., herein referred to as "the Administrator" on behalf of the Company and whose name is identified on the ID Card and/or recorded with the Administrator, subject to all of the Exclusions, Limitations and Provisions as set forth herein and in this Policy issued by the Company to the Insured Person(s). Coverage is afforded only with respect to the named Insured Person(s), benefits, amounts and limits specified herein and as identified in the Schedule of Benefits for the coverage requested on the Application/ Enrollment Form and for which the specified Premium has been paid to the Administrator.

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

IMPORTANT

Refer to ID Card for benefits and limits.

Note: certain capitalized words are defined terms in this Policy.

Eligibility: Worldwide Coverage is available to Individuals, ages 18-64, who have Eligible Scheduled Medical Treatment arranged outside of the Insured Person(s)' Home Country. Eligible Scheduled Medical Treatment must be performed outside of the United States and provided through a Medical Tour Provider, Hospital and/or Facility. Please note that all Hospitals performing Eligible Scheduled Medical Treatment must be Joint Commission International (JCI) accredited. Medical Expenses as a result of a Covered Complication(s) must be approved and arranged by the Administrator. Covered Complication(s) treated inside of the United States must be performed in an approved United States PPO Facility.

Insured Person(s) must also include Family Member(s) and/or Traveling Companions, ages 0-80, who are accompanying the Insured Person(s) who has arranged Eligible Scheduled Medical Treatment. In order to receive any benefits for Cancellation, Family Member(s) and/or Traveling Companions must be enrolled and pay the appropriate Premium. Family Member(s) and/ or Traveling Companions who have also arranged to have Eligible Scheduled Medical Treatment must also purchase the additional Medical Expense for Covered Complication(s).

The following Schedule of Benefits shows the Maximum Benefit Amounts available for this Policy.

SCHEDULE OF BENEFITS

Benefit amounts must be purchased for the full cost of the trip, up to \$40,000 per person).

BENEFIT

Trip Cancellation /Interruption

PER PERSON LIMIT

Trip Cost to a maximum of: \$40,000 (Trip Cost includes non-refundable prepaid expenses for Travel Arrangements and non-refundable prepaid deposits for Eligible Scheduled Medical Treatment.)

Trip Delay/ Missed Connection

\$500

Medical Expense for Acute Sickness or Accidental Injury which first manifests itself during the Insured Person(s)' Trip

\$50,000

Medical Expenses for Covered Complication(s) which are a result of an Eligible Scheduled Medical Treatment
(Must occur within 60 days from the date of your Eligible Scheduled Medical Treatment)

Three Options of Medical Coverage:
\$10,000/\$20,000/\$50,000 per Eligible Scheduled Medical Treatment

Emergency Medical Evacuation/ Repatriation/ Repatriation of Remains

\$100,000

Emergency Medical Evacuation/ Repatriation/ Repatriation of Remains due to Covered Complication(s) from Eligible Scheduled Medical Treatment

\$50,000, Insured Person pays 20% Co-insurance

Lost Baggage / Personal Effects

\$1,000; \$300 per article limit

Baggage Delay-Outward Journey Only	\$200
Emergency Dental Treatment as a result of an Accidental Injury to a sound natural tooth	\$750
24-Hour Accidental Death & Dismemberment	\$10,000
Common Carrier Accidental Death & Dismemberment	\$25,000
24-Hour Travel Assistance Services	Included
Optional Flight Accident per Trip	\$100,000; \$250,000; or \$500,000
Benefit Period for Covered Complication(s)	180 days from the date of the Insured Person(s)' Eligible Scheduled Medical Treatment

TRIP CANCELLATION / TRIP INTERRUPTION

Trip Cancellation:

The Insured Person(s) shall have benefits as stated in the Schedule of Benefits in the amount purchased for unused non-refundable prepaid expenses for Travel Arrangements and/or any non-refundable prepaid deposits for Eligible Scheduled Medical Treatment. The Insured Person(s) is covered for Cancellation/Interruption benefits if the Insured Person(s) is prevented from taking their Trip for any of the following reasons that occur after the Effective Date* of the Policy: *Effective Date is 12:01 a.m. following the day the Administrator receives the Insured Person(s)' Application/ Enrollment Form with the proper Premium. The Trip must commence within twelve (12) months from the Effective Date. The Policy must become Effective prior to the Insured Person(s)' Scheduled Departure Date. Maximum Trip duration is sixty (60) days.

1. Specified Acute Sickness, Injury or death of the Insured Person(s)', Business Partner or Family Member of the Insured Person(s) that results in medically imposed restrictions as certified by a Legally Qualified Physician at the time of loss, preventing the Insured Person(s)' continued participation in the Trip. A Legally Qualified Physician must advise cancellation of the Trip on or before the Scheduled Departure Date.
2. Strike that causes complete cessation of services of the Insured Person(s)' Common Carrier for at least 48 consecutive hours.
3. Weather that causes complete cessation of services of the Insured Person(s)' Common Carrier for at least 48 consecutive hours.
4. Employer termination or layoff affecting the Insured Person(s). Employment must have been with the same employer for at least five (5) continuous years.
5. Terrorism. The Terrorist Incident must occur in a city listed on the Insured Person(s)' itinerary within thirty (30) days prior to the Insured Person(s)' Scheduled Departure Date. This same city must not have experienced a Terrorist Incident within the ninety (90) days prior to the Terrorist Incident, which is causing the Insured Person(s)' cancellation.
6. The Insured Person(s) is hijacked, quarantined, required to serve on a jury, subpoenaed, the victim of felonious assault within ten (10) days of departure; or having his/her principal place of residence made uninhabitable by fire, flood or other natural disaster; or burglary of his/her principal place of residence within ten (10) days of departure.
7. The death or hospitalization of the Surgeon, Dentist, or Legally Qualified Physician who will be performing the Insured Person(s)' Eligible Scheduled Medical Treatment.
8. The Insured Person(s) or the Insured Person(s)' Family Member, who are military personnel, and are called to emergency duty for a natural disaster other than war.
9. Traffic accident directly involving the Insured Person(s) substantiated by a police report, while en route to a scheduled departure point.
10. If the Insured Person(s)' Travel Supplier, Medical Tour Provider, and/or Facility for whom you have arranged an Eligible Scheduled Medical Treatment outside the United States cancels the Insured Person(s)' Trip or Eligible Scheduled Medical Treatment, the Insured Person(s)

will receive up to \$75 for the reissue fee charged by the airline for the Insured Person(s)' tickets, if the airline tickets can be used within the next twelve (12) months. The Insured Person(s) must cover the full cost of the Trip.

11. Natural disaster at the site of the Insured Person(s)' destination that renders their destination accommodations uninhabitable.

All cancellations must be reported to the Administrator within 72 hours of the event causing the need to cancel. If the event delays the reporting of the cancellation beyond the 72 hours, report the event as soon as possible. All other delays of reporting beyond 72 hours will result in reduced benefit payments.

SINGLE OCCUPANCY COVERAGE

The Company will reimburse the Insured Person(s), up to the maximum benefit amount listed in the Schedule of Benefits, for the additional cost incurred during the Trip as a result of a change in the per person occupancy rate for prepaid Travel Arrangements if a person booked to share accommodations with the Insured Person(s) has his/her Trip delayed, cancelled, or interrupted for a covered reason and the Insured Person(s) does not cancel.

Trip Interruption: If the Insured Person(s) is prevented from completing a Trip for any of the reasons listed under the Trip Cancellation section above that occur after the Insured Person(s)' Effective Date and after the Scheduled Departure Date of the Trip, the Insured Person(s) is eligible up to the maximum benefit amount as stated in the Schedule of Benefits for:

- a) unused, non-refundable cancellation charges imposed by the Travel Supplier, Medical Tour Provider, and/or Facility;
- b) the airfare paid less the value of applied credit from an unused return travel ticket, to return home or rejoin the original Travel Arrangements (limited to the cost of one-way economy airfare or similar quality as the original issued ticket by the scheduled carrier, from the point of destination to the point of origin shown on the original travel tickets.)

The Company will pay for Additional Expenses for lodging, transportation, and meals incurred by the Insured Person(s) (up to \$150 a day) if the Insured Person(s) must remain hospitalized or if the Insured Person(s) must extend their Trip with additional hotel nights due to a Legally Qualified Physician certifying that the Insured Person(s) cannot fly home due to an Accident, Sickness, or Covered Complication(s) but does not require hospitalization.

In no event shall the amount reimbursed exceed the amount the Insured Person(s) prepaid for their Trip, and/or prepaid deposits for the Insured Person(s)' Eligible Scheduled Medical Treatment.

TRIP DELAY / MISSED CONNECTION

The Company will reimburse the Insured Person(s) for Covered Expenses on a one-time basis up to the maximum benefit amount listed in the Schedule of Benefits, if the Insured Person(s) is delayed en route to or from their Trip for six (6) or more hours due to one (1) of the following reasons:

- 1.) Any delay of a Common Carrier (including Inclement Weather);
- 2.) Any delay by a traffic accident en route to a departure, in which the Insured Person(s) is not directly involved;
- 3.) Any delay due to lost or stolen passports, travel documents or money, quarantine, hijacking, unannounced strike, natural disaster, civil commotion or riot;
- 4.) A closed roadway causing cessation of travel to the destination of the Trip (substantiated by the department of transportation, state police, etc.)

Covered Expenses include:

- (a) Any prepaid, unused, non-refundable land and water accommodations;
- (b) Any reasonable Additional Expenses incurred;
- (c) An Economy Fare from the point where the Insured Person(s) ended their Trip to a destination where the Insured Person(s) can rejoin the Trip; or
- (d) A one-way Economy Fare to return the Insured Person(s) to their originally scheduled return destination.

MEDICAL EXPENSE FOR ACUTE SICKNESS OR ACCIDENTAL INJURY

The Company will pay up to the maximum benefit amount listed in the Schedule of Benefits, if the Insured Person(s) incurs Covered Medical Expenses as a result of Emergency Treatment of an Acute Sickness or Accidental Injury that first manifests itself or occurs during the Trip.

Emergency Treatment means necessary Medical Treatment, including services and supplies, which must be performed during the Trip due to the serious and Acute nature of the Sickness or Accidental Injury.

Covered Medical Expenses are necessary services and supplies that are recommended by the attending Legally Qualified Physician. They include but are not limited to:

- (a) the services of a Legally Qualified Physician;
- (b) charges for Hospital confinement and use of operating rooms;
- (c) charges for anesthetics (including administration); x-ray examinations or treatments, and laboratory tests;
- (d) ambulance service; and
- (e) drugs, medicines, prosthetics and therapeutic services and supplies.

The Company will not pay benefits in excess of the Usual and Customary Charges. The Company will not cover any expenses provided by another party at no cost to the Insured Person(s) or already included within the cost of the Trip.

The Company will advance payment to a Hospital, up to the maximum benefit amount listed in the Schedule of Benefits, if needed to secure the Insured Person(s)' admission to a Hospital because of Sickness or Accidental Injury.

The Company will pay benefits up to the maximum benefit amount listed in the Schedule of Benefits, for emergency dental treatment for Accidental Injury to sound natural teeth.

If the Insured Person(s) is hospitalized due to an Acute Sickness or Accidental Injury (which first occurred during the course of the scheduled Trip) beyond the date of the Scheduled Return Date, coverage will be extended until the Insured Person is released from the Hospital, and/or until maximum benefits under the Policy have been paid, and/or the Insured Person(s) have reached their final destination.

MEDICAL EXPENSES FROM AN ELIGIBLE SCHEDULED MEDICAL TREATMENT RESULTING IN COVERED COMPLICATION(S)

The Company will pay up to the maximum benefit amount listed in the Schedule of Benefits. Benefits are payable only for such charges, which are a result of a separate Diagnosis, and not a result of an Adverse Outcome, incurred during the Incurral Period and within the defined Benefit Period for Covered Complication(s). The Company will pay the Usual and Customary Charges for Covered Expenses incurred by an Insured Person(s), if the Insured Person(s) sustains a Covered Complication(s) after an Eligible Scheduled Medical Treatment which was performed outside the United States.

Covered Expenses are the charges for the following Medically Necessary medical or dental services, supplies and Treatments that are incurred by an Insured Person(s) as a result of a documented and defined Covered Complication(s):

1. services of Legally Qualified Physicians, or Surgeon;
2. anesthetics and their administration;
3. laboratory tests and diagnostic testing;
4. oxygen and its administration;
5. blood and blood derivatives that are not donated or replaced, and their administration;
6. radiological procedures;
7. drugs requiring a Legally Qualified Physician's or Surgeon's prescription;
8. Hospital room and board up to the most common charge, or ICU/Trauma, when required;
9. Hospital ancillary services (including, but not limited to, use of the operating room);
10. professional ambulance service to the nearest Hospital equipped to provide the required treatment;
11. air ambulance service to a Hospital when such service is ordered by a Legally Qualified Physician and is accomplished in an aircraft used primarily for transporting sick or injured persons.

WHEN COVERED COMPLICATION(S) BENEFITS END.

Covered Expenses for a Covered Complication(s) are payable until the earlier of: a) the date the Covered Complication(s) no longer requires further treatment by a Legally Qualified Physician; b) the date the Maximum Benefit Amounts are paid; or (c) the expiration of the Benefit Period for Covered Complication(s).

MULTIPLE ELIGIBLE SCHEDULED MEDICAL TREATMENT(S) LIMITATION.

If an Insured Person(s) has more than one Eligible Scheduled Medical Treatment performed during the same Trip, any Covered Complication(s) that arise from any of the Eligible Scheduled Medical Treatment(s) will be treated as one Covered Complication and only one benefit will be payable for the Covered Complication(s).

SUCCESSIVE ELIGIBLE SCHEDULED MEDICAL TREATMENT

In order to be considered an Eligible Scheduled Medical Treatment, any succeeding procedure must be performed at least thirty (30) days after the date of the initial Eligible Scheduled Medical Treatment.

EMERGENCY MEDICAL EVACUATION/ REPATRIATION

The Company will pay benefits for Covered Expenses incurred up to the maximum benefit amount listed in the Schedule of Benefits, if an Accidental Injury or Acute Sickness, or Covered Complication(s) commencing during the course of the Trip results in the Insured Person(s)' necessary Emergency Evacuation. An Emergency Evacuation must be ordered by a Legally Qualified Physician who certifies that the severity of the Insured Person(s)' Accidental Injury or Sickness warrants the Insured Person(s)' Emergency Evacuation.

Emergency Evacuation means:

- (a) The Insured Person(s)' medical condition warrants immediate transportation from the place where the Insured Person(s) is injured or sick to the nearest Hospital where appropriate medical treatment can be obtained;
- (b) after being treated at a local Hospital, the Insured Person(s)' medical condition warrants Medically Necessary transportation to the Insured Person(s)' Home Country to obtain further Medical Treatment;
- (c) both (a) and (b), above.

Covered Expenses are Usual and Customary Charges for necessary transportation, related medical services and medical supplies incurred in connection with the Insured Person(s)' Emergency Evacuation. All transportation arrangements made for evacuating the Insured Person(s) must be by the most direct and economical route possible. Expenses for transportation must be:

- (a) recommended by the attending Legally Qualified Physician;
- (b) required by the standard regulations of the conveyance transporting the Insured Person(s); and
- (c) authorized in advance by the Company or its authorized representative.

Transportation of Dependent Children: If the Insured Person(s) is in the Hospital for more than seven (7) days following a covered Emergency Evacuation, the Company will return the Insured Person(s)' dependents, who are under 18 years of age and accompanying him/her on the scheduled Trip, to the domicile of a person nominated by the Insured Person(s) or their next of kin with an attendant if necessary. This does not include scheduled hospitalization or recovery from the Insured Person(s)' Eligible Scheduled Medical Treatment.

Transportation to Join the Insured Person(s): If the Insured Person(s) is traveling alone and is in a Hospital for more than seven (7) consecutive days or if the attending Legally Qualified Physician certifies that due to the Insured Person(s)' Acute Injury or Sickness, the Insured Person(s) will be required to stay in the Hospital for more than seven (7) consecutive days, upon request the Company will bring a person, chosen by the Insured Person(s), for a single visit to and from the Insured Person(s)' bedside provided that repatriation is not imminent. This does not include scheduled hospitalization or recovery from the Insured Person(s)' Eligible Scheduled Medical Treatment.

Transportation services are provided if authorized in advance by the assistance provider, and are limited to necessary economy fares less the value of applied credit from unused travel tickets, if applicable.

Transportation means any Common Carrier, or other land, water or air conveyance, required for an Emergency Evacuation and includes air ambulances, land ambulances and private motor vehicles.

The Company will not cover any expenses provided by another party at no cost to the Insured Person(s) or already included within the cost of the Trip.

REPATRIATION OF REMAINS

The Company will pay the reasonable Covered Expenses incurred to return the Insured Person(s)' body to the Insured Person(s)' Home Country if the Insured Person(s) dies during the Trip. This will not exceed the maximum benefit amount listed in the Schedule of Benefits.

Covered Expenses include, but are not limited to, expenses for embalming, cremation, or container for transport and transportation.

BAGGAGE/PERSONAL EFFECTS

The Company will reimburse the Insured Person(s) up to the maximum benefit amount listed in the Schedule of Benefits, for loss, theft or damage to baggage and personal effects, provided the Insured Person(s) has taken all reasonable measures to protect, save and/or recover his/her property at all times. The baggage and personal effects must be owned by and accompany the Insured Person(s) during the Trip. Please note the per article limit as stated in the Schedule of Benefits.

This coverage is secondary to any coverage provided by a Common Carrier and all other valid and collectible insurance indemnity and shall apply only when such other benefits are exhausted.

There will be a combined maximum benefit amount listed in the Schedule of Benefits for the following:

- jewelry; watches; articles consisting in whole or in part of silver, gold or platinum; furs; articles trimmed with or made mostly of fur; cameras and their accessories and related equipment.

The Company will pay the lesser of the following:

- (a) Actual Cash Value at time of loss, theft or damage to baggage and personal effects, less depreciation as determined by the Company; or
- (b) the cost of repair or replacement.

EXTENSION OF COVERAGE If the Insured Person(s) checked their property with a Common Carrier and delivery is delayed, coverage for Baggage/Personal Effects will be extended until the Common Carrier delivers the property.

BAGGAGE DELAY (Outward Journey Only)

The Company will reimburse the Insured Person(s) for the expense of necessary personal effects up to the maximum benefit amount listed in the Scheduled of Benefits, if the Insured Person(s)' Checked Baggage is delayed or misdirected by a Common Carrier for more than twenty-four (24) hours, while on a Trip, except for travel to their final destination or place of residence. The Insured Person(s) must be a ticketed passenger on a Common Carrier.

Additionally, all claims must be verified by the Common Carrier who must certify the delay or misdirection and receipts for the purchases must accompany any claim.

ACCIDENTAL DEATH AND DISMEMBERMENT

The Company will pay the percentage of the Principal Sum shown in the Table of Losses below when the Insured Person(s), as a result of an Accidental Injury occurring during the Trip, sustains a loss. The loss must occur within 180 days after the date of the Accident causing the loss. The Principal Sum is listed in the Schedule of Benefits. If more than one loss is sustained, as the result of an Accident, the amount payable shall be the largest amount of a sustained loss shown in the Table of Losses.

TABLE OF LOSSES	
Loss of:	Percentage of Principal Sum:
Life	100%
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
Either hand or foot and sight of one eye	100%
Either hand or foot	50%
Sight of one eye	50%
Speech and hearing in both ears	100%
Speech	50%
Hearing in both ears	50%
Thumb and index finger of same hand	25%

"Loss" with regard to:

1. hand or foot, means actual complete severance through and above the wrist or ankle joints;
2. eye means an entire and irrecoverable loss of sight;
3. speech or hearing means entire and irrecoverable loss of speech or hearing of both ears; and
4. thumb and index finger means actual severance through or above the joint that meets the finger at the palm.
5. Loss does not include death, loss of sight, hearing or any limbs from surgical procedures, Medical Treatments, or a Covered Complication(s).

EXPOSURE

The Company will pay benefits for covered losses that result from the Insured Person(s) being unavoidably exposed to the elements due to an Accident. The loss must occur within 365 days after the event that caused the exposure.

DISAPPEARANCE

The Company will pay benefits for loss of life if the Insured Person(s)' body cannot be located one year after their disappearance due to an Accident.

ACCIDENTAL DEATH AND DISMEMBERMENT COMMON CARRIER (AIR ONLY)

The Company will pay benefits for Accidental Injuries resulting in a loss as described in the Table of Losses below, which occurs while the Insured Person(s) is riding as a passenger in or on, boarding or alighting from, any air conveyance operated under a license for the transportation of passengers for hire during the Trip. The loss must occur within 180 days after the date of the Accident causing the loss. The Principal Sum is listed in the Schedule of Benefits. If the Insured Person(s) purchases the Flight Accidental Death Upgrade Option, the modified Principal Sum will be listed on the Insured Person(s)' ID card. If more than one loss is sustained as the result of an Accident, the amount payable shall be the largest amount shown in the Table of Losses.

TABLE OF LOSSES	
Loss of:	Percentage of Principal Sum:
Life	100%
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
Either hand or foot and sight of one eye	100%
Either hand or foot	50%

Sight of one eye	50%
Speech and hearing in both ears	100%
Speech	50%
Hearing in both ears	50%
Thumb and index finger of same hand	25%

"Loss" with regard to:

1. hand or foot, means actual complete severance through and above the wrist or ankle joints;
2. eye means an entire and irrecoverable loss of sight;
3. speech or hearing means entire and irrecoverable loss of speech or hearing of both ears; and
4. thumb and index finger means actual severance through or above the joint that meets the finger at the palm.

EXPOSURE

The Company will pay benefits for covered losses that result from the Insured Person(s) being unavoidably exposed to the elements due to an Accident of an air conveyance operated under a license for the transportation of passengers for hire during the Trip. The loss must occur within 365 days after the event that caused the exposure.

DISAPPEARANCE

The Company will pay benefits for loss of life if the Insured Person(s)' body cannot be located one year after their disappearance due to forced landing, stranding, sinking, or wrecking of an air conveyance operated under a license for the transportation of passengers for hire during the Trip in which he/she was a passenger.

POLICY DEFINITIONS

"Accident" shall mean a sudden, unexpected, unusual, specific event that occurs at an identifiable time and place, but shall also include exposure resulting from a mishap to a conveyance in which the Insured Person(s) is traveling.

"Accidental Injury" shall mean Bodily Injury caused by an Accident (of external origin) being the direct and independent cause in the loss.

"Actual Cash Value" shall mean purchase price less depreciation.

"Additional Expense" shall mean any reasonable expenses for meals, transportation and lodging which were necessarily incurred as the result of an eligible Trip Delay and which were not provided by the Common Carrier or other party free of charge.

"Acute" shall mean a disease with either or both of: a) a rapid onset; or b) a short course (as opposed to a chronic course).

"Administrator" shall mean Seven Corners, Inc., who have been selected and approved by the Company to administer the Policy.

"Adverse Outcome" shall mean an unintended or harmful physical effect resulting from an Eligible Scheduled Medical Treatment which presents a separate Diagnosis, related to and/or caused by the Eligible Scheduled Medical Treatment, and is not solely the result of an Insured Person(s)' dissatisfaction.

"Ambulatory Surgical Center" shall mean a licensed Facility providing surgical treatment, other than a Hospital or Office Surgery Center, from which the Insured Person is expected to be released on the same date the Eligible Scheduled Medical Treatment is performed.

"Application/ Enrollment Form" shall mean the form for which the Insured Person(s) provides information on their Trip and/or Eligible Scheduled Medical Treatment which is submitted and approved by the Administrator with the corresponding Premium.

"Bodily Injury" shall mean identifiable physical injury which: (a) is caused by an Accident, (b) is independent of disease or bodily infirmity, and (c) is the direct cause of death or dismemberment of the Insured Person within twelve (12) months from the date of the Accident.

"Bankruptcy" shall mean the filing of a petition for voluntary or involuntary bankruptcy, liquidation or insolvency in any court of competent jurisdiction abroad or within the United States.

"Benefit Period" shall mean the period of time for which benefits are payable. Coverage ends once the Insured Person(s) returns to their final destination, with the exception the Benefit Period for a Covered Complication(s).

"Benefit Period for a Covered Complication(s)" shall mean the number of days, as stated in the Schedule of Benefits, from the date of the Insured Person(s)' Eligible Scheduled Medical Treatment by a Legally Qualified Physician or Surgeon due to a Covered Complication(s).

"Business Partner" shall mean an individual who: a) is involved in a legal general partnership with the Insured Person(s); and b) is actively involved in the day-to-day management of the Insured Person(s)' business.

"Co-insurance" shall mean the percentage amount as stated in the Schedule of Benefits, which is the responsibility of each Insured Person(s) and must be paid by each Insured Person(s), before benefits under this Policy are payable by the Company.

"Common Carrier" shall mean any land, air or water conveyance operating under a valid license providing for the transportation of passengers for hire.

"Company" shall mean Certain Underwriters at Lloyd's of London.

"Corrective Procedure" shall mean Covered Expenses for surgical or Medical Treatment to remedy or neutralize an Adverse Outcome of an Eligible Scheduled Medical Treatment.

"Covered Expenses" shall mean expenses incurred by the Insured Person(s) which are for Medically Necessary services, supplies, care, or treatment; due to Illness or Injury; prescribed, performed or ordered by a Legally Qualified Physician; Usual and Customary Charges; incurred while insured under the Policy; and which do not exceed the maximum limits as shown in the Schedule of Benefits.

“Covered Complication(s)” shall mean physical complication(s) which are a result of a separate Diagnosis and not a result of an Adverse Outcome (a) suffered by an Insured Person(s) as the result of an Eligible Scheduled Medical Treatment; (b) that first manifest with in the Incurral Period; (c) result in the Insured Person(s)' Treatment by a Legally Qualified Physician or Surgeon at a Facility within the Benefit Period for Covered Complication(s)

Covered Complication(s) are as follows:

Cardiopulmonary Related: Myocardial Infarction, diagnostic testing and treatment to Rule Out Myocardial Infarction, Arrhythmia, Hypoxia, Pulmonary Dysfunction, diagnostic testing and treatment to Rule Out Deep Vein Thrombosis (DVT), diagnostic testing and treatment to Rule Out Pulmonary Embolus, Fluid Overload, Cardiac Arrest, Shock

Surgery Related: Hemorrhage, Hematoma, Foreign Objects left in patient after surgery, Infection

Anesthesia Related: Severe hypotension (systolic BP equal to or less than 80, three (3) hours after the Eligible Scheduled Medical Treatment), Severe hypertension (systolic BP equal to or greater than 200 or diastolic BP equal to or greater than 100, three (3) hours after the Eligible Scheduled Medical Treatment).

Post Operative: Pneumomediastinum, Latrogenic Pneumothorax, Sepsis, Pneumonia, Urinary Tract Infections

The above listed Complication(s) will only be considered Covered Complication(s), if the Insured Person(s) has followed all pre- and post-operative instructions including attending all Post-Operative Examination Visits, physical therapy, post operative care, and medication.

"Default" shall mean the material failure or inability to provide contracted services due to a material financial insolvency.

"Dentist" shall mean a legally licensed doctor of dental surgery, dental medicine or dental science.

"Diagnosis" shall mean a disease or medical condition defined by it's outward signs and symptoms.

"Economy Fare" shall mean the lowest published rate for a one-way round trip economy ticket.

"Effective Date" begins at 12:01 a.m. following the day the Administrator receives the Insured Person(s)' enrollment with the appropriate Premium.

"Eligible Scheduled Medical Treatment" shall mean one or more elective procedures performed by a Surgeon at a Facility outside the United States. Any procedures performed in a Hospital must be recognized by the Joint Commission on the Accreditation of Hospitals and/ or Joint Commission International (JCI). To obtain a list of Eligible Scheduled Medical Treatment(s), please visit www.sevencorners.com/ESMT.pdf

"Experimental/Investigational and/or for Research" shall mean a Treatment(s), drug, device procedure, supply or service and related services (or a portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists:

1. The Treatment(s), drug, device, procedure, supply or service is in any clinical trial or a Phase I, II or III trial.
2. The Treatment(s), drug, device, procedure, supply or service is not yet fully approved or recognized by a pertinent governmental agency or professional organization such as the National Cancer Institute or Food & Drug Administration.
3. The results are not proven through controlled clinical trials with results published in peer-reviewed English language medical journals to be of greater safety and efficacy than conventional Treatment(s), in both the short and long term.
4. The Treatment(s), drug, device, procedure, supply or service is not generally accepted medical practice in the state or Country where the Insured Person(s) resides or as generally accepted throughout the relevant medical community by reference to any one or more of the following: peer-reviewed English-language medical literature, Consultation(s) with Legally Qualified Physician(s), authoritative medical compendia, the American Medical Association, or other pertinent professional organization or governmental agency.
5. The Treatment(s), drug, device, procedure, supply or service is described as Investigational, Experimental, a study, or for Research or the like in any consent, release, or authorization which the Insured Person(s) or someone acting on their behalf may be required to sign. The fact that a procedure, service, supply, Treatment(s), drug, or device may be the only hope for survival will not change the fact that it is otherwise Investigational, Experimental, or for Research.

"Facility" shall mean a Hospital, Ambulatory Surgical Center, or Dental Treatment Center.

"Family Member" shall mean any of the following who resides in the Insured Person(s)' country of residence: The Insured Person(s)' legal or common law spouse, parent, legal guardian, step-parent, grandparent, parents-in-law, grandchild, natural or adopted child, step-child, children-in-law, brother, sister, step-brother, step-sister, brother-in-law, sister-in-law, aunt, uncle, niece or nephew.

"General Anesthesia" includes, but is not limited to: endotracheal anesthesia, epidural anesthesia, local anesthesia, regional anesthesia, spinal anesthesia, and topical anesthesia.

"Home Country" shall mean the country where an Insured Person(s) has his or her true, fixed and permanent residence.

"Hospital" shall mean a Facility or Treatment in a Facility that: (1) is operated according to law for the care and Treatment of injured or sick people; (2) has organized facilities for Diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (3) has 24-hour nursing service by registered nurses (R.N.'s); and (4) is supervised by one or more Legally Qualified Physicians. (5) is recognized as a general Hospital by the Joint Commission on the Accreditation of Hospitals and/ or Joint Commission International (JCI). This only applies for Eligible Scheduled Medical Treatment. A Hospital does not include: (1) a nursing, convalescent or geriatric unit of a Hospital when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the Hospital that is used for such purposes; or (3) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

"Incurral Period" shall mean the sixty (60) day period immediately following the date the Insured Person(s)' Eligible Scheduled Medical Treatment.

"Inclement Weather" shall mean any severe weather condition that delays the scheduled arrival or departure of a Common Carrier.

"Insured Person" shall mean a person eligible for benefits under this Policy. Individuals receiving Eligible Scheduled Medical Treatment, ages 18-64, and/or Traveling Companions who are not receiving treatment, ages 0-80, who have applied for coverage and are named on the Application/ Enrollment Form and for whom the Administrator has accepted Premium.

"Intoxicants" shall mean being under the influence of or disablement due wholly or partly to the effects of intoxicating liquor or drugs, other than drugs taken in accordance with Treatment(s) prescribed and directed by a Legally Qualified Physician(s) for a condition which is covered hereunder, but not for the Treatment(s) of drug addiction;

"Intoxicated" shall mean being under the influence of Intoxicants, or having a blood alcohol level which equals or exceeds the legal limit for operating a motor vehicle in the jurisdiction where you are located at the time of an incident.

"Legally Qualified Physician" shall mean a physician or a practitioner or Surgeon: a) other than the Insured Person(s) or the Insured Person(s)' Family Member; b) practicing within the scope of his or her license; and c) recognized as a physician in the jurisdiction where the services are rendered.

"Loss" shall mean Bodily Injury, Accidental Injury or damage sustained by the Insured Person(s) in consequence of happening of one or more of the occurrences against which the Company has undertaken to indemnify the Insured Person(s). This does not include death from surgical procedures, Medical Treatments, or death from a Complication(s).

"Medical Tour Provider" shall mean any entity or organization that coordinates or supplies Eligible Scheduled Medical Treatment(s) performed outside the United States.

"Medical Treatment" shall mean Treatment, advice or consultation by a Legally Qualified Physician.

"Medically Necessary" shall mean a service or supply which: a) is recommended by the attending Legally Qualified Physician; b) is appropriate and consistent with the Diagnosis in accordance with accepted standards of community practice; c) could not have been omitted without adversely affecting the Insured Person(s)' condition or quality of medical care; d) is delivered at the most appropriate level of care and not primarily for the sake of convenience; and e) is not considered Experimental unless law requires payment of benefits for Experimental service or supplies.

"Mental Illness" shall mean Mental, emotional, and psychiatric disorders, Sickness(es) or conditions (whether organic or non-organic, whether biological, non-biological, genetic, chemical or non-chemical in origin). Mental and nervous disorders include, but are not limited to psychoses; neurotic disorders; bipolar disorders; affective disorders; personality disorders; psychological or behavioral abnormalities, associated with transient or permanent dysfunction of the brain or related neurohormonal systems; and disorders, conditions, and Sickness(es) listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders IV-R or the most recent edition of the International Classification of Disease(s) ICD-9-CM, which is the required reporting tool for all Diagnoses and disease(s) to all U.S. Public Health Service and Health Care Financing Administration programs on the date the medical care or Treatment(s) is rendered to an Insured Person(s).

"Policy" shall mean the insurance coverage provided within this document including the Application/ Enrollment form, any riders and the Insured Person(s)' ID card.

"Post Operative Examination Visits" shall mean regular post procedure check ups with the Surgeon or Legally Qualified Physician who performed the Eligible Scheduled Medical Treatment. This includes physical therapy, post operative care and medication.

"Premium" shall mean the corresponding monetary amount in United States Dollars charged by the Company and collected by the Administrator for the coverage afforded in this Policy.

"Pre-existing Conditions" as used or referenced in this Policy for all benefits listed in the Schedule of Benefits, with the exception of Medical Expenses for Covered Complication(s), shall mean any Accidental or Bodily Injury, Sickness or condition (including any condition from which death ensues) of the Insured Person(s), the Insured Person(s)' Family Member, or Traveling Companion who is booked on the same Trip as the Insured Person(s), which within the sixty (60) day period prior to the Effective Date of the Policy: a) manifested itself, or exhibited symptoms which would have caused one to seek Diagnosis, care or Treatment; b) required taking of prescribed drugs or medicine, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; c) required Medical Treatment, or Treatment was recommended by a Legally Qualified Physician or; d) the condition for which the Insured Person(s) has arranged for an Eligible Scheduled Medical Treatment.

"Scheduled Departure Date" shall mean the date on which the Insured Person(s) is originally scheduled to leave on their Trip.

"Scheduled Return Date" shall mean the date on which the Insured Person(s) is originally scheduled to return to the point of origin or the original final destination.

"Schedule of Benefits" shall mean this Policy and the benefit confirmation provided to the Insured Person(s) following enrollment and payment of the applicable Premium for the Insured Person(s)' Policy.

"Sedation" includes, but is not limited to: intravenous sedation, conscious sedation, and moderate sedation as administered by a Legally Qualified Physician.

"Sickness" shall mean an illness or disease which is diagnosed or treated by a Legally Qualified Physician after the Insured Person(s)' Effective Date under this Policy and prior to the Insured Person(s)' Scheduled Return Date.

"Strike" shall mean any unannounced labor disagreement that interferes with the normal departure of a Common Carrier.

"Surgeon" shall mean a Legally Qualified Physician who: (a) is licensed and certified in the surgical discipline to be performed, as required in the jurisdiction in which the Eligible Scheduled Medical Treatment is performed; and (b) is a member of a professional society or association of Legally Qualified Physicians specializing in the type of Eligible Scheduled Medical Treatment to be performed if such societies exist and are generally accepted as having authority concerning medical practice in the jurisdiction in which the Eligible Scheduled Medical Treatment is performed.

"Terrorist Incident" shall mean an incident deemed a terrorist act by the United States Government that causes property damage and or loss of life.

"Transportation Expense" shall mean: a) The cost of conveyance of the Insured Person(s) and any medical personnel (if Medically Necessary); and b) The cost of Medically Necessary services or supplies.

"Travel Arrangements" shall mean: a) transportation; b) accommodations; and c) other specified services arranged by the Travel Supplier for the Trip.

"Traveling Companion" shall mean person(s) booked to accompany the Insured Person(s) on their Trip and are also an Insured Person(s) as defined in this Policy.

"Treatment(s)" shall mean medical or surgical management of a patient designed to resolve the Sickness(es) or Bodily Injury/Injury(ies) based on standard and accepted medical practice. For purposes of this Policy, the course of action will only include those scheduled and approved benefits, as defined in this Policy, for which the Insured Person(s) is eligible.

"Travel Supplier" shall mean any Medical Tour Provider, hotel, entity or organization that coordinates or supplies travel services or Travel Arrangements for the Insured Person(s).

"Trip" shall mean scheduled Travel Arrangements through a Travel Supplier, Medical Tour Provider, and/or Facility on behalf of the Insured Person(s) for purposes of having an Eligible Scheduled Medical Treatment performed outside of the United States. Maximum Trip duration is sixty (60) days.

"Usual and Customary Charges" shall mean those comparable charges for similar Treatment, services and supplies in the geographic area where the Treatment is performed, and does not include charges that would not have been made if no insurance existed.

"United States" shall mean the 50 states of the United States of America and the District of Columbia.

"United States PPO Facility" shall mean a Hospital, Legally Qualified Physician or medical Facility approved by the Administrator or found on the following web-site link: www.sevencorners.com/ppo

LIMITATIONS AND EXCLUSIONS

The following exclusions apply to all benefits listed in the Schedule of Benefits:

Loss caused by or resulting from:

1. Pre-Existing Conditions, as defined in the Policy Definitions section (except Emergency Medical Evacuation/ Repatriation and Repatriation of Remains)
2. suicide, attempted suicide or any intentionally self-inflicted injury while sane or insane unless results in the death of a non-traveling immediate Family Member; for an Insured Person(s) suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury or acts of autoeroticism;
3. intentionally self-inflicted injuries;
4. War, hostilities or warlike operations (whether war be declared or not), Invasion, Act of an enemy foreign to the nationality of the Insured Person(s) or the country in, or over, which the act occurs, Civil war, Riot, Rebellion, Insurrection, Revolution, Overthrow of the legally constituted government, Civil commotion assuming the proportions of, or amounting to, an uprising, Military or usurped power, Explosions of war weapons, Utilization of Nuclear, Chemical or Biological weapons of mass destruction howsoever these may be distributed or combined, Murder or Assault subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the Insured Person(s) whether war be declared with that state or not.

For the purpose of this Exclusion;

- ii) Utilization of Nuclear weapons of mass destruction means the use of any explosive nuclear weapon or device or the emission, discharge, dispersal, release or escape of fissile material emitting a level of radioactivity capable of causing incapacitating disablement or death amongst people or animals.
- iii) Utilization of Chemical weapons of mass destruction means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing incapacitating disablement or death amongst people or animals.
- iv) Utilization of Biological weapons of mass destruction means the emission, discharge, dispersal, release or escape of any pathogenic (Disease(s) producing) micro-organism(s) and/or biologically produced toxin(s) including genetically modified organisms and chemically synthesised toxins) which are capable of causing incapacitating disablement or death amongst people or animals.

Also excluded is any Loss or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, or suppressing any, or all, of the situations described above. In the event any portion of this exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and effect;

5. participation in any military maneuver or training exercise any loss starting while the Insured Person(s) are in the service of the armed forces of any country. Orders to active military service for training purposes of two (2) months or less will not constitute service in the armed forces. Upon notice to the Company of entering the armed forces, the Company will return to the Insured Person(s) pro-rata any premium paid, less any benefits paid, for any period during which the Insured Person(s) are in such service;
6. piloting or learning to pilot or acting as a member of the crew of any aircraft;
7. mental or emotional disorders, unless hospitalized;
8. participation as a professional in athletics;
9. participation in underwater activities;

10. being under the influence of drugs or Intoxicants, unless prescribed by a Legally Qualified Physician, unless resulting in the death of a non-traveling immediate Family Member, expenses for Treatment in connection with alcoholism and drug addiction, or use of any drug or narcotic agent; any Mental Illness disorders or rest cures;
11. commission or the attempt to commit a criminal act;
12. participating in bodily contact sports; skydiving; hang-gliding; parachuting; mountaineering; any race; bungee cord jumping; and speed contest - speed contest shall not include any of the regatta races, scuba diving, spelunking or caving, heliskiing, extreme skiing;
13. dental treatment except as a result of an Accidental Injury to sound natural teeth within twelve (12) months of the Accidental Injury limited to the maximum benefit amount listed in the Schedule of Benefits, with the exception of the Insured Person(s)' Eligible Scheduled Medical Treatment which results in a Covered Complication(s);
14. any non-emergency treatment or surgery, routine physical examinations, hearing aids, eye glasses or contact lenses;
15. pregnancy and childbirth (except for complications of pregnancy) except if hospitalized;
16. curtailment or delayed return for other than covered reasons;
17. traveling for the purpose of securing medical treatment, unless for Eligible Scheduled Medical Treatment of the Insured Person(s);
18. services or expenses not shown as covered;
19. directly or indirectly, the actual, alleged or threatened discharge, dispersal, seepage, migration, escape, release or exposure to any hazardous biological, chemical, nuclear radioactive material, gas, matter or contamination;
20. Confinement or Treatment in a government Hospital; however the United States government may recover or collect benefits under certain conditions;
21. Care or Treatment that is not Medically Necessary;
22. Care or Treatment for which compensation is payable under Worker's Compensation Law, any Occupational Disease law; or similar legislation or any other individual, government, or group policy or charges provided at no cost to the Insured Person(s);
23. Care or Treatment that is payable under any Insurance policy that does not require deductible and/or co-insurance payments by the Insured Person(s);
24. Injury or Sickness when traveling against the advice of a Legally Qualified Physician;
25. Cosmetic surgery except for: reconstructive surgery incidental to or following surgery for trauma, or infection or other covered disease of the part of the body reconstructed, or to treat a congenital malformation of a child, with the exception of the Insured Person(s)' Eligible Scheduled Medical Treatment which results in a Covered Complication(s);
26. Bankruptcy and/or Default of Your Travel Supplier, Medical Tour Provider, and/or Facility;
27. Expenses for Loss due to death, loss of sight, hearing or any limbs from surgical procedures, Medical Treatments, or a Covered Complication(s).

WHAT IS NOT PAYABLE UNDER LOST BAGGAGE/PERSONAL EFFECTS, BAGGAGE DELAY BENEFIT:

Benefits are not payable for loss of any of the following: 1.) animals; 2.) automobile or automobile equipment; 3.) boats or other vehicles or conveyances; 4.) trailers; 5.) motors; 6.) motorcycles; 7.) aircraft; 8.) bicycles (except when checked as baggage with a Common Carrier); 9.) household effects and furnishings; 10.) antiques or collectors items; 11.) eye glasses, sunglasses or contact lenses; 12.) artificial teeth or dental bridges; 13.) hearing aids; 14.) prosthetic limbs; 15.) prescribed medications; 16.) keys, money, stamps, securities and documents; 17.) tickets; 18.) credit cards; 19.) professional or occupational equipment or property (whether or not electronic business equipment); 20.) personal computers, telephones, computer hardware or software; 21.) sporting equipment if loss or damage results from the use thereof.

Any loss caused by or resulting from the following is exclude

1.) breakage of brittle or fragile articles; 2.) wear and tear or gradual deterioration; 3.) insects or vermin; 4.) inherent vice or damage while the article is actually being worked upon or processed; 5.) confiscation or expropriation by order of any government; 6.) war or any act of war whether declared or not; 7.) mysterious disappearance; 8.) theft or pilferage while left unattended in any vehicle; 9.) property illegally acquired, kept, stored or transported; 10.) insurrection or rebellion; 11.) imprudent action or omission; 12.) property shipped as freight or shipped prior to the Scheduled Departure Date

The following exclusions apply to Hotel/Motel Burglary:

1.) cash; 2.) checks; 3.) securities; 4.) credit cards; 5.) other negotiable instruments; 6.) tickets; 7.) documents; 8.) coins; 9.) deeds; 10.) bullion; 11.) stamps; 12.) business items; 13.) personal computers; 14.) forcible exit; 15.) eyeglasses, sunglasses, contact lenses, hearing aids, artificial teeth and limbs

The Company will not pay for delay, loss of market, or consequential losses or damages of any kind.

ADDITIONAL EXCLUSIONS FOR COVERED COMPLICATION(S) FROM AN ELIGIBLE SCHEDULED MEDICAL TREATMENT

No coverage shall be provided and no payment shall be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks:

1. Medical expenses that are a result of an Insured Person(s)' dissatisfaction with the results of an Eligible Scheduled Medical Treatment.
2. Expenses that exceed the Usual and Customary Charges for the same medical issue; or
3. Expenses incurred inside the United States and not within a United States PPO Facility as approved by the Administrator;
4. traveling against the recommendation of the Insured Person(s)' Legally Qualified Physician before or after an Eligible Scheduled Medical Treatment;
5. Expenses incurred in the United States which have not been pre-notified to the Administrator;
6. Expenses for replacement or rectification of prostheses, corrective devices, medical appliances, and standard surgical implants, unless required for the Treatment of a Covered Complication(s);
7. Expenses for postoperative stress, insomnia, or other sleep disorder, or other forms of psychological stress, including anguish, loss of enjoyment, or pain and suffering;
8. Expenses for vocational, occupational, speech, recreational, or music therapy;
9. Expenses resulting from the Insured Person's non-compliance with a Legally Qualified Physician's orders;
10. Expenses resulting from Post Operative Exams Visits, physical therapy, post operative care and medication recommended and prescribed by a Legally Qualified Physician for the Eligible Scheduled Medical Treatment;
11. Expenses resulting from Treatment which is Experimental/Investigational and/or for Research purposes;
12. Expenses incurred when traveling against the advice of a Legally Qualified Physician who restricted travel; 1.) associated with the Eligible Scheduled Medical Treatment, or 2.) associated with Covered Complication(s) arising from the Eligible Scheduled Medical Treatment;
13. Expenses for Loss due to death, loss of sight, hearing or any limbs from surgical procedures, Medical Treatments, or a Covered Complication(s).

No coverage is eligible for the Covered Complication(s) benefit if the Eligible Scheduled Medical Treatment involves one of the following:

14. Expenses incurred for organ or tissue transplants;
15. Expenses for gender reassignment;
16. Expenses for any Treatments related to the cardiovascular system;
17. Expenses for pregnancy, complications of pregnancy or childbirth; expenses for fetal intervention surgery in-utero;
18. Expenses for Treatment involving the brain stem, spinal cord, or the central nervous system
19. Expenses incurred in the United States which have not been pre-notified to the Administrator;
20. Expenses for the treatment of any cancer.
21. Expenses incurred when traveling against the advice of a Legally Qualified Physician who restricted travel; 1.) associated with the Scheduled Medical Treatment, or 2.) associated with Covered Complication(s) arising from the Scheduled Medical Treatment;
22. Expenses for onset of Covered Complication(s) arising from a Scheduled Medical Treatment performed in a Hospital, which is not Joint Commission International (JCI) accredited;
23. Expenses for Loss due to death, loss of sight, hearing or any limbs from surgical procedures, Medical Treatments, or a Covered Complication(s).

This Policy does not cover any of a Surgeon(s)' liability, including but not limited to liability:

1. arising out of Bodily Injury, sickness, death or disease sustained by any person, arising out of any act, error, or omission in providing or failing to provide professional services. This includes anyone for whose acts, errors, or omissions for which a Surgeon is responsible;
2. assumed by a Surgeon under any contract with any other party other than the arrangement between a Surgeon and the Insured Person(s);
3. that is due to an association or affiliation in any business or professional organization;
4. arising from any dishonest, fraudulent, criminal, or malicious acts, whether intentional or negligent;
5. due to a violation of any anti-trust, price fixing, or restraint of trade law, whether based upon statute, common law, or administrative directive;
6. arising from sexual intimacy, sexual molestation, sexual harassment, sexual exploitation, or sexual assault of any kind;
7. under any unemployment, workers compensation, disability benefits, or similar law;
8. pursuant to any order of court, judge, arbitrator or arbitration panel, administrator, governmental agency, or licensing body;
9. arising from the use of any non-FDA (or the appropriate authoritative agency in the jurisdiction in which the Eligible Scheduled Medical Treatment or Corrective Procedure was incurred) approved medication, device, or equipment; or
10. peer review, quality assurance, or utilization review done on behalf of any managed care or insurance organization.

POLICY PROVISIONS

The following provisions apply to all benefits listed in this Policy:

WHEN YOUR COVERAGE BEGINS

Effective Date begins at 12:01 a.m. following the day the Administrator receives the Insured Person(s) enrollment with the appropriate Premium. The Policy must become Effective prior to the Insured Person(s)' Scheduled Departure Date.

Trip Cancellation Benefit and Assistance Services begin on the Effective Date.

Common Carrier Accidental Death Benefit begins on the Scheduled Departure Date and ends when the Trip is completed or after sixty (60) days, whichever comes first.

Trip Delay Benefit is in force while the Insured Person(s) is en route to and from the Insured Person(s)' Trip.

All Other Benefits begin on 12:01 a.m. on the Insured Person(s)' Scheduled Departure Date or whichever is later, and ends at the point and time of return on or before the Scheduled Return Date. Maximum trip length is sixty (60) days.

WHEN YOUR COVERAGE ENDS – Your coverage will end at 11:59 p.m. local time on the date that is the earliest of the following:

- (a) the date the Policy is terminated;
- (b) the Scheduled Return Date as stated on the travel tickets;
- (c) the date the Insured Person(s) returns to their origination point if prior to the Scheduled Return Date;
- (d) the date the Insured Person(s) leaves or changes their Trip (unless due to unforeseen and unavoidable circumstances covered by the Policy);
- (e) the date the Policy terminates;
- (f) If the Insured Person(s) extends their Trip for a Covered Complication(s), the Insured Person(s)' coverage will terminate at 11:59 p.m., local time, at the Insured Person(s) location on the originally Scheduled Return Date;
- (g) The date the Insured Person(s) cancels the Trip;
- (h) Any Trip that exceeds sixty (60) days.

EXTENDED COVERAGE: Coverage will be extended under the following conditions: (a) If the Insured Person(s) is a passenger on a scheduled Common Carrier that is unavoidably delayed in reaching the final destination coverage will be extended for the period of time needed to arrive at the final destination.

ENTIRE CONTRACT; CHANGES: The Policy, including the Application/ Enrollment Form, Schedule of Benefits, Exclusionary Rider(s), endorsements and the attached papers, if any, constitutes the entire contract of Insurance. No change in the Policy shall be valid until approved by an executive officer of the Administrator and unless such approval is endorsed hereon. No agent has authority to change this Policy or to waive any of its provisions.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within thirty (30) days after the occurrence or commencement of any Covered Expense(s) covered by the Policy. If notice cannot be given within thirty (30) days because of incapacity or some similar reason, it must be given as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Administrator, or to any authorized agent of the Company, with the name of the Insured Person(s) and the Policy Number on the ID Cards to identify the Insured Person(s) shall be deemed notice to the Company.

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 Covered Event(s) for which claim is made.

PROOF OF LOSS: Written Proof of Loss must be furnished to the Administrator, at its said office, within ninety (90) days after the date of such Covered Expense. 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. In any case, the proof required must be given no later than one (1) year from the time specified except in the absence of legal capacity.

PAYMENT OF CLAIMS: Subject to any written direction of the Insured Person(s) which is submitted within the time for filing the Proof of Loss, all or a portion of any indemnities provided by this Policy for Hospital, nursing, medical or Surgical service may, at the Company's option, be paid directly to the Hospital or Service Provider rendering such services.

Benefits for loss of life are payable to the Insured Person(s)' beneficiary. If a beneficiary is not otherwise designated by the Insured Person(s), benefits for loss of life will be paid to the first of the following surviving preference beneficiaries:

- a) The Insured Person(s)' spouse;
- b) The Insured Person(s)' child or children jointly;
- c) The Insured Person(s)' parents jointly if both are living or the surviving parent if only one survives;
- d) The Insured Person(s)' brothers and sisters jointly; or
- e) The Insured Person(s)' estate.

All other claims will be paid to the Insured Person(s). In the event the Insured Person(s) is a minor, incompetent or otherwise unable to give a valid release for the claim, the Company may make arrangements to pay claims to the Insured Person(s)' legal guardian, committee or other qualified representative.

Any payment made in good faith will discharge the Company's liability to the extent of the claim.

The applicable benefit amount will be reduced by the amount of benefits, if any, previously paid by other Insurance Policies. In no event will the Company reimburse the Insured Person(s) for an amount greater than the amount paid by the Insured Person(s).

PHYSICAL EXAMINATION AND AUTOPSY: The Company, at its own expense shall have the right and opportunity to examine the person of any individual whose Injury(ies) or Illness(es) 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.

LEGAL ACTIONS: It is agreed that in the event of the failure of the Company hereon to pay any amount claimed to be due hereunder, the Company hereon, at the request of the Insured Person(s), will submit to the jurisdiction of a Court of competent jurisdiction within the United States. Nothing in this Clause constitutes or should be understood to constitute a waiver of Company's rights to commence an action in any Court of competent Jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another Court as permitted by the laws of the United States or of any State in the United States. It is further agreed that service of process in such suit may be made upon Mendes and Mount; 750 Seventh Avenue; New York, NY 10019-6829 USA, and that in any suit instituted against any one of them upon this contract, Company will abide by the final decision of such Court or of any Appellate Court in the event of an appeal.

The above-named are authorized and directed to accept service of process on behalf of Company in any such suite and/or upon the request of the Insured Person(s) to give a written undertaking to the Insured Person(s) that they will enter a general appearance upon Company's behalf in the event that such a suit shall be instituted.

Further, pursuant to any statute of any state, territory or district of the United States which makes provision therefore, Company hereon hereby designate the Superintendent, Commissioner or Director of Insurance or other officer specified for that purpose in the statute, or his successor or successors in office, as their true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the Insured Person(s) or any beneficiary hereunder arising out of this contract of insurance, and hereby designate the above-named as the person to whom the said officer is authorized to mail such process or a true copy thereof.

NOT IN LIEU OF WORKER'S COMPENSATION: This Insurance is not in lieu of and does not affect any requirements for Coverage by Worker's Compensation Insurance.

POLICY OF INSURANCE: The Company shall issue to each Insured Person(s) an individual Policy of Insurance which shall state the essential features of Insurance to which such person is entitled and to whom benefits are payable, if required to do so by the laws of the jurisdiction in which the Insured Person(s) resides when his Insurance becomes effective.

DATA FURNISHED BY INSURED PERSON(S): Insured Person(s) shall furnish all information requested on the Application/ Enrollment Form and/or claim form and any additional information requested by the Company.

The refusal or failure of the Insured Person(s)' Family Member(s), Traveling Companion, Employer, insurance company, Legally Qualified Physician(s), Hospital or Service Provider to make all medical reports and records available to the Company could cause an otherwise valid claim or Application/ Enrollment Form to be denied or the file to be closed due to lack of or limited reply from the above referenced individuals and entities. Failure on the part of the Insured Person(s) to maintain adequate documentation regarding travel history could cause an otherwise valid claim (where travel history is material to the benefit and claim) to be denied or the file to be closed.

The Company has the option whether or not to consider medical information provided by friends / Family Member(s) of the Insured Person(s) as valid for underwriting or claim administration.

EXCESS BENEFITS: All Coverage shall be in excess of all other valid and collectible insurance and shall apply only when such benefits are exhausted.

Other valid and collectible insurance for which benefits may be payable are insurance programs provided by:

- 1.) Individual, group or blanket insurance or coverage;
- 2.) Other prepayment coverage provided on a group or individual basis;
- 3.) Any coverage under labor management trustee plans, union welfare plans, employer organizational plans, employee benefit organization plans, or other arrangement of benefits for individuals of a group;
- 4.) Any coverage required or provided by any statute, socialized insurance program; or
- 5.) Any no-fault automobile insurance;
- 6.) Any third party liability insurance.

SUBROGATION: The Company has the right to full subrogation and reimbursement of any and all amounts paid by the Company to or on behalf of, an Insured Person(s), if the Insured Person(s) receives any sum of money from any person, plan or legal entity which is legally obligated to make payments arising out of any act or omission of any person whether a third party or another covered person under the Policy, which directly or indirectly caused a physical or Mental condition, in connection with which payment of any benefits under the Policy to, or on behalf of, such Insured Person(s) was made. The Policy shall have a lien against such sum of money received from third parties or other persons described above or their insurers, or the insurer of the Insured Person(s), and shall be reimbursed there from. The Insured Person(s) further agrees to notify other persons described above in writing, of the Policy's subrogation and lien rights before the receipt of any payment from said parties or other persons.

The Insured Person(s) shall be responsible for all expenses of recovery from such parties or other persons, including but not limited to, all attorneys' fees incurred in collection of such payments or payments by other persons, which fees and expenses shall not reduce the amount of reimbursement to the Policy required of the Insured Person(s). The Insured Person(s) agrees to reimburse the Policy for any benefit paid hereunder, out of any monies recovered from such party or other persons as a result of judgment, settlement or otherwise, even though such monies are not characterized as amounts paid for medical expenses or claims. The Insured Person(s) agrees to furnish such information and assistance, and to execute and deliver all necessary instruments, as the Company or its designee may request to facilitate the enforcement of these subrogation rights, including but not limited to the execution of a subrogation agreement prior to payments of benefits under the Policy to, or on behalf of the Insured Person(s).

The Insured Person(s) shall not release or discharge any party from his or her obligation to the Insured Person or the Policy or take any other action, which could impair the Policy's subrogation rights. The Policy's exercise of its rights, to take whatever action it sees fit against any third party or other persons, shall not affect the Insured Person(s)'s right to pursue other forms of recovery.

If the Insured Person(s), or any one acting on his or her behalf, has not taken action to pursue his or her rights against such parties or other persons to obtain a judgment, settlement or other recovery, the Company or its designee, upon giving thirty (30) days written notice to the Insured Person(s) shall have the right to take such action in the name of the Insured Person(s) to recover that amount of benefits paid under the Policy; provided, however, that any action taken without the consent of the Insured Person(s) shall be without prejudice to such Insured Person(s).

The Policy's right to reimbursement as set forth herein shall be payable first from sums received from the parties or other persons and such reimbursement shall continue until the Insured Person(s)' obligations hereunder to the Policy are fully discharged, even though the Insured Person(s) does not receive full compensation or recovery for his/her Injury(ies), damages loss or debt. This right to subrogation shall exist in all cases.

If an Insured Person(s) fails to comply with these requirements, the Insured Person(s) shall not be eligible to receive any benefits, services or payments under the Policy until there is compliance, regardless of whether such benefits are related to the act or omission of such party or other persons.

MONTEARY LIMITS: The monetary limits stated in this Policy and the Premium shall be in United States dollars. For services outside of the territorial limits of the United States, the exchange rate used to determine the amount of United States dollars to be paid is the exchange rate effective for the date the claims expense was incurred.

ASSIGNMENT: The Insurance provided hereunder is not assignable, but benefits may be assigned in accordance with, Payment of Claims.

INCONTESTABILITY: After two (2) years from the Effective Date of Individual Insurance, only fraudulent misstatements in the Application/ Enrollment Form may be used to Void the Policy or deny any claim for Loss, Eligible Benefits or disability starting after the two (2) year period.

REPRESENTATIONS IN APPLICATION/ ENROLLMENT FORM: Any statement or description made by or on behalf of the Insured Person(s) on the Application/ Enrollment Form for Insurance Coverage is a representation and is not a warranty. A misrepresentation, omission, concealment of fact, or incorrect statement may prevent recovery under the Policy only if any of the following apply; a.) the misrepresentation, omission, concealment, or statement is fraudulent or is material either to the Approval of the Coverage for the Insured Person(s) or payment of otherwise Eligible Benefits by the Company, b.) if the Administrator or Company had known the facts prior to issuance of Coverage, the Administrator or Company would not have issued Coverage, would not have issued Coverage at the same Premium.

PATIENT SUPPORT: To ensure that Medically Necessary services, supplies and Treatment(s) are provided in the most cost effective and appropriate manner, the Company may determine that a particular claim or diagnosis occurring under this Insurance may be placed under the patient support program. Once the Insured Person(s) follows the Pre-Notification requirement and the Company determines that the condition (or Diagnosis) qualifies for the patient support requirement, the Company will advise the Insured Person(s) that a Patient Support Specialist will be assigned to the Insured Person(s) for that particular condition. From that point forward, the Company's Patient Support Specialist may make recommendations of alternative Treatment(s) in the form of other locations, other procedures, or other supplies that can be used that are more appropriate and/or cost effective for both the Insured Person(s) and the Company (and will result in the same or better care). The Insured Person(s) and the Insured Person(s)' Legally Qualified Physician(s) will have input in this evaluation. Should the recommendations be accepted by the Insured Person(s), the Insured Person(s) agrees to hold the Company harmless and the Company shall not be held liable or otherwise responsible for any Treatment(s), service, supply, procedure or care provided to the Insured Person(s) except for the payment of benefits under this Insurance. After the Insured Person(s) has been notified that the condition meets the Patient Support program requirements, the Company reserves the right to:

- a. Generate payment for Treatment(s), services, and/or supplies which are excluded under this Insurance that would be beneficial to the Insured Person(s) and cost effective to the Company; and

- b. Decline payment for expenses that would otherwise be covered under this Insurance that exceed the amount the Company would have paid had the Insured Person(s) followed the recommended Treatment(s) program established by the patient support program.

FIFTEEN (15) DAY RIGHT TO RETURN POLICY: If for any reason you are not satisfied with this Policy or any amendment/endorsement that has been added and made a part of this Policy, the Insured Person(s) may return it to the Administrator within fifteen (15) days after you receive it. The Insured Person(s) must return it to the Administrator by mail or to the agent who sold it. The Administrator will refund any Premium paid and the Policy will be deemed Void, just as though no Policy had been issued.

COMPLAINTS: Any initial inquiry or complaint should be addressed to the Administrator, as defined herein. If the Insured Person(s) is not satisfied with the manner in which an inquiry or complaint has been managed by the Administrator, the Insured Person(s) may request in writing to the Complaints & Advisory Department at Lloyd's to review the case without prejudice to your rights in law.

Complaints and Advisory Department of Lloyd's
1 Lime Street
London EC3M 7HA
United Kingdom

SETTLEMENT OF LOSS - Claims for damage and/or destruction shall be paid after acceptable proof of the damage and/or destruction is presented to the Company and the Company has determined the claim is covered. Claims for lost property will be paid after the lapse of a reasonable time if the property has not been recovered. The Insured Person(s) must present acceptable proof of loss and the value involved to the Company.

VALUATION - The Company will not pay more than the Actual Cash Value of the property at the time of loss. Damage will be estimated according to Actual Cash Value with proper deduction for depreciation as determined by the Company. At no time will payment exceed what it would cost to repair or replace the property with material of like kind and quality.

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the loss either the Insured Person(s) or the Company can make a written demand for an appraisal. After the demand, the Insured Person(s) and the Company will each select their own competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount of the loss. If they do not agree, they will select an arbitrator. Any figure agreed to by 2 of the 3 (the appraisers and the arbitrator) will be binding. The appraiser selected by the Insured Person(s) is paid by the Insured Person(s). The Company will pay the appraiser they choose. The Insured Person(s) will share equally with the Company the cost for the arbitrator and the appraisal process.

IMPORTANT: To facilitate prompt claims settlement, the Insured Person(s) will be asked to provide proof of payment for travel accommodations and the Insured Person(s)' Eligible Scheduled Medical Treatment. 1.) For cancellation/interruption claims – The Insured Person(s)' travel invoice, the cancellation or interruption date, original unused tickets/vouchers, the Travel Supplier's or Medical Tour Provider's cancellation clause with regard to nonrefundable losses. The Insured Person(s) will also be asked to provide proof of payment of the Insured Person(s)' loss. Therefore, be sure to obtain the following as applicable: 2.) For medical claims - detailed medical statements from treating Legally Qualified Physicians where and when the Accidental Injury or Sickness occurred as well as receipts for medical services and supplies, requirement for medical procedure invoice along with cancellation clause with regards to non-refundable losses; 3.) For baggage and baggage delay claims - reports from parties responsible (i.e. airline, etc.) for loss, theft, damage or delay. Some claims may also require a police report. Please obtain receipts for lost, stolen, or damaged items; 4.) For trip delay claims - a statement from party causing delay and receipts for expenses;

No benefits will be paid for any expenses reimbursed to the Insured Person(s) or services provided to the Insured Person(s) by any other source. Benefits cannot be duplicated under the Insured Person(s)' Policy.

TRAVEL ASSISTANCE SERVICES

The Travel Assistance feature provides a variety of travel related services. Services offered include: Medical Evacuation / Repatriation · Repatriation of remains · Medical or legal referral · Hospital admission guarantee · Emergency cash advance* · Translation service · Prescription drug / eyeglass replacement* Passport / visa information · Inoculation information

* Payment reimbursement to the Administrator is responsibility of the Insured Person(s).

For Travel Assistance Services ONLY:

CALL TOLL FREE: 800-690-6295 (within the United States and Canada)

OR CALL COLLECT: 317-818-2808 (from all other locations worldwide)

FOR QUESTIONS AND GENERAL INFORMATION REGARDING YOUR BENEFITS OR FILING A CLAIM

To receive a claim form, contact Seven Corners, or send your name, address, travel dates, confirmation number (provided on ID Card) and details of loss within 30 days to:

Seven Corners, Inc.
303 Congressional Blvd.
Carmel, IN 46032

800-335-0477 or 317-575-2656 (Monday thru Friday 8:00 A.M. to 5:00 P.M. EST)

Fax: 317-575-2256

Email: medtour.claims@sevencorners.com