



Nationwide Mutual Insurance Company
PO Box 2399
Columbus OH 43216-2399
Mail Code C0-03-24

This Certificate of Coverage describes all of the travel insurance benefits, underwritten by a Nationwide Mutual Insurance Company and herein referred to as the Company, and assistance services provided by Seven Corners Assist. The insurance benefits and assistance services vary from program to program. Please refer to the accompanying Confirmation of Coverage. It provides You with specific information about the program You purchased. Please contact Seven Corners immediately if You believe that the Confirmation of Coverage is incorrect.

This Certificate of Coverage is issued in consideration of the enrollment form and payment of any premium due. All statements in the enrollment forms are representations and not warranties. Only statements contained in a written enrollment form will be used to void insurance, reduce benefits or defend a claim.

NO DIVIDENDS WILL BE PAYABLE UNDER THE GROUP POLICY.

The President and Secretary of Nationwide Mutual Insurance Company witness the Group Policy.

Secretary

President

TRAVEL PROTECTION CERTIFICATE

**TRAVEL PROTECTION CERTIFICATE
EXCESS INSURANCE**

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GENERAL DEFINITIONS

Accident means 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 You are traveling.

Accidental Injury means Bodily Injury caused by an accident (of external origin) being the direct and independent cause in the loss.

Actual Cash Value means purchase price less depreciation.

Additional Expense means any reasonable expenses for meals and lodging which were necessarily incurred as the result of a Hazard and which were not provided by the Common Carrier or other party free of charge.

Bankruptcy means the filing of a petition for voluntary or involuntary bankruptcy in a court of competent jurisdiction under Chapter 7 or Chapter 11 of the United States Bankruptcy Code 11 L.S.C. Subsection 101 et seq.

Bodily Injury means 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 You within twelve months from the date of the Accident.

Business Partner means an individual who: (a) is involved in a legal partnership; and (b) is actively involved in the day-to-day management of the business.

Common Carrier means any land, sea, and/or air conveyance operating under a valid license for the transportation of passengers for hire.

Company means Nationwide Mutual Insurance Company .

Covered Expenses shall mean expenses incurred by You which are for medically necessary services, supplies, care, or treatment; due to illness or injury; prescribed, performed or ordered by a Physician; reasonable and customary charges; incurred while insured under the Plan; and which do not exceed the maximum limits shown in the Confirmation of Coverage, under each stated benefit.

Cruise means any prepaid sea arrangements made by the Participating Organization.

Default means a material failure or inability to provide contracted services due to financial insolvency.

Dependent means Your lawful spouse and/or unmarried children under 19 years of age.

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

Effective Date means the date and time Your coverage begins, as outlined in the General Provisions section of this Certificate.

Exotic Vehicles includes Alfa Romeo, Aston Martin, Auburn, Avanti, Bentley, Bertone, BMC/Leyland, BMW M Series, Bradley, Bricklin, Cosworth, Citroen, Clenet, De Lorean, Excalibre, Ferrari, Fiat, Iso, Jaguar, Jensen, Jensen Healy, Lamborghini, Lancia, Lotus, Maserati, MG, Morgan, Pantera, Panther, Pininfarina, Rolls Royce, Rover, Stutz, Sterling, Triumph, TVR and Yugo.

Family Member means You or Your Traveling Companion'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, who reside in the United States, Canada or Mexico.

Hazard means:

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

Hospital means a facility that:

- (a) holds a valid license if it is required by the law;
- (b) operates primarily for the care and treatment of sick or injured persons as in-patients;
- (c) has a staff of one or more Physicians available at all times;
- (d) provides 24 hour nursing service and has at least one registered professional nurse on duty or call;
- (e) has organized diagnostic and surgical facilities, either on the premises or in facilities available to the hospital on a pre-arranged basis; and
- (f) is not, except incidentally, a clinic, nursing home, rest home, or convalescent home for the aged, or similar institution.

Host at Destination means a person with whom You are sharing pre-arranged overnight accommodations at the host's usual principal place of residence.

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

Individual Coverage Term means the period of time beginning when You have been enrolled for coverage under the Plan and for whom the required premium has been paid.

Insurance means any one of the following types of policies or plans which provide benefits for hospital confinement, medical expenses for You on Your effective date of coverage, and such policy or plan requires You to pay a deductible and/or portion of coinsurance: individual, group or blanket insurance plans; group Blue Cross, Blue Shield, or other group prepayment coverage plans; coverage under labor management trustee plans, union welfare plans, employer organization plans, employee benefit organizational plans, or other arrangements of benefits for persons of a group. Insurance does not include Medicare or Medicaid.

Land/Sea Arrangements means any activities undertaken by You while in the Individual Coverage Term.

Loss means injury or damage sustained by You in consequence of happening of one or more of the occurrences against which the Company has undertaken to indemnify You.

Physician means a licensed practitioner of medical, surgical or dental services acting within the scope of his/her license. The treating Physician may not be You, a Traveling Companion or a Family Member.

Pre-Existing Condition means any injury, sickness or condition of You, Your Traveling Companion, Your Family Member booked to travel with You for which within the sixty (60) day period prior to the effective date of Trip Cancellation coverage under the Plan (a) first manifested itself or exhibited symptoms which would have caused one to seek diagnosis, care or treatment; (b) required taking 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; or (c) required medical treatment or treatment was recommended by a Physician.

The Pre-Existing Conditions exclusion is waived for You if You enroll in the Plan at the time You pay the deposit required for his or her Trip (or within 10 days of the initial deposit) and You purchase the coverage under the Plan for the full cost of their Trip.

Scheduled Departure Date means the date on which You are originally scheduled to leave on the Trip.

Scheduled Return Date means the date on which You are originally scheduled to return to the point of origin or to a different final destination.

Sickness means an illness or disease which is diagnosed or treated by a Physician after the effective date of insurance and while You are covered under the Plan.

Strike means any unannounced labor disagreement that interferes with the normal departure and arrival of a Common Carrier.

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

Traveling Companion means person(s) booked to accompany You on Your Trip (to a maximum of four (4) persons including You). Note, a group or tour leader is not considered a Traveling Companion unless You are sharing room accommodations with the group or tour leader.

Travel Supplier means tour operator, cruise line, hotel etc. who has made the land and/or sea arrangements.

Trip means prepaid Land/Sea Arrangements and shall include flight connections to join or depart such Land/Sea Arrangements provided such flights are scheduled to commence within one day of the Land/Sea Arrangements. Maximum Trip duration is 90 days.

You or Your refers to all persons listed on the Confirmation of Coverage under the program purchased by You.

GENERAL PROVISIONS

The following provisions apply to all coverages:

WHEN YOUR COVERAGE BEGINS - All coverage (except Trip Cancellation) will take effect at 12:01 A.M. local time, at Your location on the Scheduled Departure Date provided:

- (a) coverage has been elected; and
- (b) the required premium has been paid.

Trip Cancellation coverage will take effect at 12:01 A.M. local time at Your location, on the date the required premium for such coverage is received by the Company or its authorized representative.

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

- (a) the date the Plan is terminated or the date the Participating Organization no longer participates in the program, unless You purchased insurance prior to the date of termination. If insurance was purchased prior to the date of termination, insurance will continue to the end of the Individual Coverage Term;
- (b) the Scheduled Return Date as stated on the travel tickets;
- (c) the date You return to Your origination point if prior to the Scheduled Return Date;
- (d) the date You leave or change Your Trip (unless due to unforeseen and unavoidable circumstances covered by the Policy);
- (e) the time the Plan terminates. If insurance was purchased prior to the date of termination, insurance will continue to the end of the Individual Coverage Term;
- (f) If You extend the return date, Your coverage will terminate at 11:59 P.M., local time, at Your location on the Scheduled Return Date;
- (g) The date You cancel the Trip;
- (h) Any Trip that exceeds 90 days.

EXTENDED COVERAGE - Coverage will be extended under the following conditions:

- (a) When You commence air travel from Your origination point: within two (2) days before the commencement of the Land/Sea Arrangements, coverage shall apply from the time of departure from the origination point; or (ii) greater than two (2) days before the commencement of the Land/Sea Arrangements, the extension of coverage shall be provided only during his/her air travel.
- (b) If You return to Your origination point: within two (2) days after the completion of the Land/Sea Arrangements, coverage shall apply until the time of return to the origination point; or (ii) greater than two (2) days after the completion of the Land/Sea Arrangements, the extension of coverage shall be provided only during his/her air travel.
- (c) If You are 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.

In no event will coverage be extended for unscheduled extensions to Your Trip for which premium has not been paid in advance.

ARBITRATION - Notwithstanding anything in this Policy to the contrary, any claim arising out of or relating to this contract, or its breach, will be settled by arbitration administered by the American Arbitration Association in accordance with the Uniform Arbitration Act (710 ILCS 5/1 et seq. except to the extent provided otherwise in this clause. Judgment upon the award rendered in such arbitration may be entered in any court having jurisdiction thereof. All fees and expenses of the arbitration shall be borne by the parties equally. However, each party will bear the expense of its own counsel, experts, witnesses, and preparation and presentation of proofs. The arbitrators are precluded from awarding punitive, treble or exemplary damages, however so denominated. If more than one Insured is involved in the same dispute arising out of the same Policy and relating to the same loss or claim, all such Insureds will constitute and act as one party for the purposes of the arbitration. **Such arbitration will be voluntary, will be by mutual consent by all parties, and may be binding upon all parties or non-binding on You. Nothing in this clause will be construed to impair Your rights to assert several, rather than joint, claims or defenses.**

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives proof of loss. No legal action for a claim can be brought against the Company more than two (2) years after the time required for giving proof of loss.

CONTROLLING LAW - Any part of the Plan that conflicts with the state law where the Plan is issued is changed to meet the minimum requirements of that law.

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

The following provisions will apply to Trip Cancellation, Trip Interruption, Trip Delay, Missed Connection, Accidental Death & Dismemberment, Air Common Carrier Accidental Death & Dismemberment, Emergency Sickness Medical Expense, Emergency Accident Medical Expense, Emergency Evacuation, Repatriation of Remains, Flight Accidental Death and Dismemberment:

PAYMENT OF CLAIMS - The Company, or its designated representative, will pay a claim after receipt of acceptable proof of loss. Benefits for loss of life are payable to Your beneficiary. If a beneficiary is not otherwise designated by You, benefits for loss of life will be paid to the first of the following surviving preference beneficiaries:

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

All other claims will be paid to You. In the event You are a minor, incompetent or otherwise unable to give a valid release for the claim, the Company may make arrangement to pay claims to Your legal guardian, committee or other qualified representative.

All or a portion of all other benefits provided by the Plan may, at the option of the Company, be paid directly to the provider of the service(s). All benefits not paid to the provider will be paid to You.

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 You for an amount greater than the amount paid by You.

NOTICE OF CLAIM - Written notice of claim must be given by the Claimant (either You or someone acting for You) to the Company or its designated representative within twenty (20) days after a covered loss first begins or as soon as reasonably possible. Notice should include Your name, the Participating Organization's name and the Plan number. Notice should be sent to the Company's administrative office, at the address shown on the cover page of the Plan, or to the Company's designated representative.

PROOF OF LOSS - The Claimant must send the Company, or its designated representative, proof of loss within ninety (90) days after a covered loss occurs or as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY - The Company, or its designated representative, at their own expense, have the right to have You examined as often as reasonable necessary while a claim is pending. The Company, or its designated representative, also has the right to have an autopsy made unless prohibited by law.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability, will be paid immediately upon receipt of due written proof.

All claims shall be paid within 30 days following receipt by the Company of due proof of loss. Failure to pay within such period shall entitle the claimant to interest at the rate of 9 percent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. You or Your assignee shall be notified by the Company or designated representative of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim. Any required interest payments shall be made within 30 days after the payment.

The following provisions apply to Baggage/Personal Effects, Lost Baggage, and Baggage Delay coverages:

NOTICE OF LOSS - If Your property covered under the Plan is lost, stolen or damaged, You must:

- (a) notify the Company, or its authorized representative as soon as possible;
- (b) take immediate steps to protect, save and/or recover the covered property;
- (c) give immediate notice to the carrier or bailee who is or may be liable for the loss or damage;
- (d) notify the police or other authority in the case of robbery or theft within twenty-four (24) hours.

PROOF OF LOSS - You must furnish the Company, or its designated representative, with proof of loss. This must be a detailed sworn statement. It must be filed with the Company, or its designated representative within ninety (90) days from the date of loss. Failure to comply with these conditions shall invalidate any claims under the Plan.

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. You 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 You or the Company can make a written demand for an appraisal. After the demand, You and the Company will each select Your 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 You is paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process.

BENEFITS

TRIP CANCELLATION

The Company will pay a benefit, up to the maximum shown on the Confirmation of Coverage, if You are prevented from taking Your Trip due to:

(a) Sickness, Accidental Injury or death of You, Traveling Companion, or Family Member or Business Partner; which results in medically imposed restrictions as certified by a Physician at the time of loss preventing Your continued participation in the Trip. A Physician must advise cancellation of the Trip on or before the Scheduled Departure Date.

- (b) You or a Traveling Companion being hijacked, quarantined, required to serve on a jury, subpoenaed, the victim of felonious assault within 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 10 days of departure.
- (c) You or a Traveling Companion being directly involved in a traffic accident substantiated by a police report, while en route to departure.
- (d) A transfer of You by the employer with whom You are employed on the Effective Date that requires Your principal residence to be relocated.
- (e) The death or hospitalization of Your Host at Destination.
- (f) A Terrorist Incident that occurs in a city listed on Your Trip itinerary and within 30 days prior to your Scheduled Departure Date. This same city must not have experienced a Terrorist Incident within the 90 days prior to the Terrorist Incident that is causing the cancellation of Your Trip. Benefits are not provided if the Travel Supplier offers a substitute itinerary. Your Scheduled Departure Date must be no more than 15 months beyond Your Effective Date.
- (g) Your Traveling Companion or Family Member, who are military personnel, and are called to emergency duty for a natural disaster other than war.
- (h) Strike that causes complete cessation of services for at least 48 consecutive hours.
- (i) Weather that causes complete cessation of services of the Common Carrier for at least 48 consecutive hours.
- (j) Bankruptcy and/or Default of Your Travel Supplier which occurs more than 10 days following Your Effective Date. Coverage is not provided for the Bankruptcy or Default of the agency from whom You purchased the Land/Sea Arrangements. Your Scheduled Departure Date must be no more than 15 months beyond Your Effective Date. Benefits will be paid due to Bankruptcy or Default of an airline only if no alternate transportation is available. If alternate transportation is available, benefits will be limited to the change fee charged to allow You to transfer to another airline in order to get to Your intended destination.
- (k) You are terminated, or laid off from employment subject to five years of continuous employment at the place of employment where terminated.
- (l) Natural disaster at the site of Your destination that renders their destination accommodations uninhabitable.

The Company will reimburse You for the following:

- a) non-refundable cancellation charges imposed by the Participating Organization and/or Travel Suppliers;
- b) If the Travel Supplier cancels Your Trip, You are covered up to \$75.00 for the reissue fee charged by the airline for the tickets. You must have covered the entire cost of the Trip including the airfare.

In no event shall the amount reimbursed exceed the amount You prepaid for the Trip.

Coverage does not include default of a Participating Organization or other organization that results in loss of services.

SPECIAL CONDITIONS: You must advise the Participating Organization and the Company as soon as possible in the event of a claim. The Company will not pay benefits for any additional charges incurred that would not have been charged had You notified the Participating Organization as soon as reasonable possible.

SINGLE OCCUPANCY COVERAGE

The Company will reimburse You, up to the maximum shown on the Confirmation of Coverage, 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 You has his/her Trip delayed, canceled, or interrupted for a covered reason and You do not cancel.

TRIP INTERRUPTION

The Company will pay a benefit, up to the maximum shown on the Confirmation of Coverage, if You are unable to continue on Your Trip due to:

- (a) Sickness, Accidental Injury or death of You, Traveling Companion, or Family Member or Business Partner; which results in medically imposed restrictions as certified by a Physician at the time of loss preventing Your continued participation in the Trip.
- (b) You or a Traveling Companion being hijacked, quarantined, required to serve on a jury, subpoenaed, the victim of felonious assault within 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 10 days of departure.
- (c) You or a Traveling Companion being directly involved in a traffic accident substantiated by a police report, while en route to departure.
- (d) a transfer of You by the employer with whom You are employed on their Effective Date which requires his/her principal residence to be relocated.
- (e) the death, or hospitalization of Your Host at Destination.
- (f) A Terrorist Incident that occurs in a city listed on Your Trip itinerary and within 30 days prior to your Scheduled Departure Date. This same city must not have experienced a Terrorist Incident within the 90 days prior to the Terrorist Incident that is causing the cancellation of Your Trip. Benefits are not provided if the Travel Supplier offers a substitute itinerary. Your Scheduled Departure Date must be no more than 15 months beyond Your Effective Date.
- (g) Your Traveling Companion or Family Member, who are military personnel, and are called to emergency duty for a natural disaster other than war.
- (h) Strike that causes complete cessation of services for at least 48 consecutive hours.
- (i) Weather that causes complete cessation of services of the Common Carrier for at least 48 consecutive hours.
- (j) Bankruptcy and/or Default of the Travel Supplier which occurs more than 10 days following Your Effective Date. Coverage is not provided for the Bankruptcy or Default of the agency from whom You purchased their Land/Sea Arrangements. Your Scheduled Departure Date must be no more than 15 months beyond the Your Effective Date. Benefits will be paid due to Bankruptcy or Default of an airline only if no alternate transportation is available. If alternate transportation is available, benefits will be limited to the change fee charged to allow You to transfer to another airline in order to get to Your intended destination.
- (k) You are terminated, or laid off from employment subject to five years of continuous employment at the place of employment where terminated.
- (l) Natural disaster at the site of Your destination that renders the destination accommodations uninhabitable.

The Company will pay for the following:

- a) unused, non-refundable land or sea expenses prepaid to the Participating Organization Travel Suppliers;
- b) the airfare paid less the value of applied credit from an unused return travel ticket, to return home or rejoin the original Land/Sea Arrangements (limited to the cost of one-way economy airfare or similar quality as originally issued ticket by scheduled carrier, from the point of destination to the point of origin shown on the original travel tickets).

The Company will pay for reasonable additional accommodation and transportation expenses incurred by You (up to \$100 a day) if a Traveling Companion must remain hospitalized or if You must extend the Trip with additional hotel nights due to a Physician certifying that You cannot fly home due to an Accident or a Sickness but does not require hospitalization.

In no event shall the amount reimbursed exceed the amount You prepaid for the Trip.

TRIP DELAY

The Company will reimburse You for Covered Expenses on a one-time basis, up to the maximum shown in the Confirmation of Coverage, if You are delayed en route to or from the Trip for twelve (12) or more hours due to a defined Hazard:

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 You ended Your Trip to a destination where You can catch up to the Trip; or
- (d) A one-way Economy Fare to return You to Your originally scheduled return destination.

MISSED CONNECTION

This benefit covers missed Cruise departures that result from cancellation or delay (for three or more hours) of all regularly scheduled airline flights due to Inclement Weather or any Common Carrier caused delay. Maximum benefits of up to the amount shown in the Confirmation of Coverage are provided to cover additional transportation expenses needed for You to join the departed Cruise, reasonable accommodation and meal expenses (up to the per day amount shown in the Confirmation of Coverage) and nonrefundable trip payments for the unused portion of Your Cruise. Coverage is secondary to any compensation provided by a Common Carrier. Coverage will not be provided to individuals who are able to meet their scheduled departure but cancel their Cruise due to Inclement Weather.

ACCIDENTAL DEATH AND DISMEMBERMENT

The Company will pay the percentage of the Principal Sum shown in the Table of Losses when You, as a result of an Accidental Injury occurring during the Trip, sustain a loss shown in the Table below. The loss must occur within 180 days after the date of the Accident causing the loss. The Principal Sum is shown on the Confirmation of Coverage. The maximum benefits for any one single Accident is limited to \$15,000,000 for all persons insured under the Plan. 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.

EXPOSURE

The Company will pay benefits for covered losses that result from Your 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 Your body cannot be located one year after Your 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, that occurs while You are 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 shown Confirmation of Coverage. The maximum benefits for any one single Accident is limited to \$15,000,000 for all persons insured under the Plan.

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 You 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 Your body cannot be located one year after Your 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.

EMERGENCY SICKNESS MEDICAL EXPENSE

The Company will pay benefits up to the maximum shown on the Confirmation of Coverage, if You incur Covered Medical Expenses as a result of Emergency Treatment of a Sickness that first manifests itself 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.

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

- (a) the services of a Physician;
- (b) charges for Hospital confinement and use of operating rooms;
- (c) charge 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 reasonable and customary charges. Reasonable and customary charges means charges commonly used by Physicians in the locality in which care is furnished. The Company will not cover any expenses provided by another party at no cost to You or already included within the cost of the Trip.

The Company will advance payment to a Hospital, up to the maximum shown on the Confirmation of Coverage, if needed to secure Your admission to a Hospital because of Sickness.

If You are hospitalized due to a Sickness (which first occurred during the course of the scheduled Trip) beyond the date of the Scheduled Return Date, coverage will be extended until You are released from the Hospital or until maximum benefits under the Plan have been paid.

EMERGENCY ACCIDENT MEDICAL EXPENSE

The Company will pay benefits up to the maximum shown on the Confirmation of Coverage, if You incur Covered Medical Expenses for Emergency Treatment of an Accidental Injury that 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 Accidental Injury.

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

- (a) the services of a 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, prosthetic and therapeutic services and supplies.

The Company will not pay benefits in excess of the reasonable and customary charges. Reasonable and customary charges means charges commonly used by Physicians in the locality in which care is furnished. The Company will not cover any expenses provided by another party at no cost to You or already included within the cost of the Trip.

The Company will pay benefits, up to \$750.00, for emergency dental treatment for Accidental Injury to sound natural teeth.

The Company will advance payment to a Hospital, up to the maximum shown on the Confirmation of Coverage, if needed to secure Your admission to a Hospital because of Accidental Injury.

If You are hospitalized due to an 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 You are released from the Hospital or until maximum benefits under the Plan have been paid.

EMERGENCY EVACUATION AND REPATRIATION OF REMAINS

EMERGENCY EVACUATION

The Company will pay benefits for Covered Expenses incurred, up to the maximum shown on the Confirmation of Coverage, if an Accidental Injury or Sickness commencing during the course of the Trip results in Your necessary Emergency Evacuation. An Emergency Evacuation must be ordered by a Physician who certifies that the severity of Your Accidental Injury or Sickness warrants Your Emergency Evacuation.

Emergency Evacuation means:

- (a) Your medical condition warrants immediate transportation from the place where You are injured or sick to the nearest Hospital where appropriate medical treatment can be obtained;
- (b) after being treated at a local Hospital, Your medical condition warrants transportation to the United States where You reside, to obtain further medical treatment or to recover; or
- (c) both (a) and (b), above.

Covered Expenses are reasonable and customary expenses for necessary transportation, related medical services and medical supplies incurred in connection with Your Emergency Evacuation. All transportation arrangements made for evacuating You must be by the most direct and economical route possible. Expenses for transportation must be:

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

Transportation of Dependent Children: If You are in the Hospital for more than seven (7) days following a covered Emergency Evacuation, the Company will return Your dependents, who are under 18 years of age and accompanying him/her on the scheduled Trip, to the domicile of a person nominated by You or Your next of kin with an attendant if necessary.

Transportation to Join You: If You are traveling alone and is in a Hospital alone for more than seven (7) consecutive days or if the attending Physician certifies that due to Your Injury or Sickness, You 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 You, for a single visit to and from Your bedside provided that repatriation is not imminent.

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 You or already included within the cost of the Trip.

EXCESS INSURANCE LIMITATION

The insurance provided by the Plan shall be in excess of all other valid and collectible insurance or indemnity. If at the time of the occurrence of any loss there is other valid and collectible insurance or indemnity in place, the Company shall be liable only for the excess of the amount of loss, over the amount of such other insurance or indemnity, and applicable deductible.

REPATRIATION OF REMAINS

The Company will pay the reasonable Covered Expenses incurred to return Your body to the United States if You die during the Trip. This will not exceed the maximum shown on the Confirmation of Coverage.

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

BAGGAGE/PERSONAL EFFECTS

The Company will reimburse You, up to the maximum shown on the Confirmation of Coverage, for loss, theft or damage to baggage and personal effects, provided You have 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 You during the Trip.

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 per article limit shown on the Confirmation of Coverage.

There will be a combined maximum limit shown on the Confirmation of Coverage 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; personal computers, 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 You checked Your 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 You for the expense of necessary personal effects, up to the maximum shown on the Confirmation of Coverage, if Your 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 final destination or place of residence.

You 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.

OPTIONAL - COLLISION DAMAGE WAIVER

Note: this benefit is not available if traveling to the following countries: Israel, Jamaica, Republic of Ireland or Northern Ireland.

If You rent a car while on the Trip, and the car is damaged due to collision, theft, vandalism, windstorm, fire, hail, flood or any cause not within Your control while in Your possession, the Company will pay the lesser of:

- (a) The cost of repairs and rental charges imposed by the rental company while the car is being repaired; or
- (b) The Actual Cash Value of the car, meaning purchase price less depreciation; or
- (c) The amount shown on the Confirmation of Coverage.

Coverage is provided to You, provided You and Your Traveling Companions are licensed drivers, and are listed on the rental agreement.

OPTIONAL - FLIGHT ACCIDENTAL DEATH AND DISMEMBERMENT

You are eligible for benefits as the result of an accident:

1. Received while a passenger on a regularly scheduled airline flight or regularly scheduled charter operated; in scheduled air transportation pursuant to economic authority issued by the Civil Aeronautics Board; by an intrastate scheduled airline of United States registry maintaining regularly published schedules and licensed for the transportation of passengers by a duly constituted authority having jurisdiction over civil aviation in the state in which said airline operates; or by a scheduled airline of foreign registry maintaining regularly published schedules and licensed for transportation of passengers by the duly constituted governmental authority having jurisdiction over civil aviation in the country of registry of such airline;
2. Received while a passenger on any aircraft, other than a single-engine jet, which at the time is making a flight for the principal purpose of transporting passengers and not for any other operational, tactical or test purpose and which is operated by the Military Airlift Command of the United States, the Royal Canadian Air Force Air Transport Command, or the Royal Air Force Air Transport Command of Great Britain;
3. Received while a passenger on any land or water conveyance provided at the expense of the air carrier as a substitute for an aircraft covered by this policy;
4. Received while a passenger on a vehicle licensed to carry passengers for hire, but only when:
 - ◆ going to an airport to board an aircraft on which the Insured is covered by this policy; or
 - ◆ when leaving an airport after alighting from such an aircraft;
5. Received while upon airport premises designated for passenger use immediately before boarding or immediately after alighting from an aircraft on which the Insured is covered under this policy.

Benefits will be paid equal to the amount purchased for accidental death or dismemberment when the Insured sustains Injuries resulting in any of the following losses within 180 days from the date of the accident:

Type of Loss Percentage of Chosen Benefit Paid

Loss of Life 100%, Loss of both feet 100%, Loss of both hands 100%, Loss of both eyes 100%, Loss of one hand and one foot 100%, Loss of one hand and one eye 100%, Loss of one foot and one eye 100%, Loss of one hand 50%, Loss of one foot 50%, Loss of one eye 50%.

Loss of hand or hands, or foot or feet, means severance at or above the wrist joint or ankle joint, respectively. Loss of eye or eyes means the total and irrecoverable loss of the entire sight thereof. Only the largest applicable amount shown above will be paid for the Injuries resulting from one accident. The benefit for loss of: a) two extremities; b) both eyes; or c) one extremity and one eye is payable only when such loss results from the same accident.

If, while covered by this benefit, the Insured is unavoidably exposed to the elements because of an eligible accident and suffer a loss for which benefits are payable under this benefit, such loss will be payable under this policy. If, while eligible for this benefit, the Insured is in an accident resulting in the disappearance, sinking or damaging of an air or water conveyance on which the Insured is scheduled under this policy, and the Insured's body has not been found within 52 weeks from the date of the accident, it will be presumed, unless there is evidence to the contrary, that the Insured suffered a loss of life as a result of those Injuries.

Flight Accident Option also includes a medical expense feature that pays Eligible Expenses up to \$50 for each \$1,000 of the chosen benefit amount. If medical expense occurs within 52 weeks of an eligible accident, the Insured will be paid for Eligible Medical Expenses as well as home health care from a licensed home health agency, but only if continued Hospital care would have otherwise been required; attendance of a registered graduate nurse; x-ray examination; or, use of an ambulance. Loss must occur within 100 days of the accident. To receive benefits, loss must be independent of illness or disease and all other causes.

LIMITATIONS AND EXCLUSIONS

The following exclusions apply to Trip Cancellation, Trip Interruption, Trip Delay, Missed Connection, Accidental Death & Dismemberment, Air Common Carrier Accidental Death & Dismemberment, Flight Emergency Sickness Medical Expense, Emergency Accident Medical Expense, Emergency Evacuation, Repatriation of Remains, Accidental Death and Dismemberment:

Loss caused by or resulting from:

1. Pre-Existing Conditions, as defined in the Definitions section (except Emergency Evacuation and Repatriation of Remains) unless the insurance is purchased within 10 days of the initial Trip deposit;
2. suicide, attempted suicide or any intentionally self-inflicted injury while sane or insane (in Missouri, sane only) unless results in the death of a non-traveling immediate Family Member;
3. intentionally self-inflicted injuries;
4. war, invasion, acts of foreign enemies, hostilities between nations (whether declared or not), civil war;
5. participation in any military maneuver or training exercise any loss starting while You are in the service of the armed forces of any country. Orders to active military service for training purposes of two 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 You pro-rata any premium paid, less any benefits paid, for any period during which You 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 Physician, unless results in the death of a non-traveling immediate Family Member;
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 injury to sound natural teeth within twelve (12) months of the Accidental Injury limited to \$750;
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;
18. services 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; the 4800 Time Benefit plan or similar legislation;
23. Care or treatment that is payable under any Insurance policy that does not require deductible and/or coinsurance payments by You;
24. Injury or Sickness when traveling against the advice of a 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.

The following exclusions apply to Baggage/Personal Effects, Baggage Delay:

The Company will not provide benefits for any loss or damage to:

1. animals;
2. automobiles and 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 and collectors items;
11. eye glasses, sunglasses or contact lenses;
12. artificial teeth and 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 excluded:

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. theft or pilferage while left unattended in any vehicle;
8. mysterious disappearance;
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.

The following exclusions apply to Collision Damage Waiver:

1. Any obligation You assume under any agreement (except insurance collision deductible);
2. Rentals of trucks, campers, trailers, off-road or four-wheel drive vehicles, motor bikes, motorcycles, recreational vehicles or Exotic Vehicles;
3. Any loss that occurs if You are in violation of the rental agreement;
4. Failure to report the loss to the proper local authorities and the rental car company;
5. Damage to any other vehicle, structure or person as a result of a covered loss.

The following duties in the event of loss apply to Collision Damage Waiver:

1. You must take all reasonable, necessary steps to protect the vehicle and prevent further damage to it;
2. You must report the loss to the appropriate local authorities and the rental company as soon as possible;
3. You must obtain all information on any other party involved in an Accident, such as name, address, insurance information and driver's license number;
4. You must provide the Company all documentation such as rental agreement, police report and damage estimate.

COORDINATION OF BENEFITS

Applicability

The Coordination of Benefits ("COB") provision applies to This Plan when You have health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan.

The benefits of This Plan:

- (a) will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
- (b) may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described further in the section entitled Effect on the Benefits of This Plan.

Definitions

Plan is a form of written on an expense incurred basis that provides benefits or services for, or because of, medical or dental care or treatment. "Plan" includes:

- (a) group insurance and group remittance subscriber contracts;
- (b) uninsured arrangements of group coverage;
- (c) group coverage through HMO's and other prepayment, group practice and individual practice Plans; and
- (d) blanket contracts, except blanket school accident coverages or a similar group when the Policyholder pays the premium.

"Plan" does not include individual or family:

- (a) insurance contracts;
- (b) direct payment subscriber contracts;
- (c) coverage through HMO's; or (d) coverage under other prepayment, group practice and individual practice Plans.

This Plan is the parts of this blanket contract that provide benefits for health care expenses on an expense incurred basis.

Primary Plan is one whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if either:

- (a) the Plan either has no order of benefit determination rules, or it has rules that differ from those in the contract; or
- (b) all Plans that cover the person use the same order of benefits determination rules as in this contract, and under those rules the Plan determines its benefits first.

Secondary Plan is one that is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this contract decide the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of this contract, has its benefits determined before those of that Secondary Plan.

Allowable Expense is the necessary, reasonable, and customary item of expense for health care; when the item of expense is covered at least in part under any of the Plans involved.

The difference between the cost of a private hospital room and a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered both an Allowable Expense and a benefit paid.

Claim is a request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of:

- (a) services (including supplies);
- (b) payment for all or a portion of the expenses incurred; or
- (c) a combination of (a) and (b).

Claim Determination Period is the period of time, which must not be less than 12 consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine:

- (a) whether overinsurance exists; and
- (b) how much each Plan will pay or provide.

For the purposes of this contract, Claim Determination Period is the period of time beginning with the effective date of coverage and ending 12 consecutive months following the date of loss or longer as may be determined by the proof of loss provision.

Order of Benefit Determination Rules

When This Plan is a Primary Plan, its benefits are determined before those of any other Plan and without considering another Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of any other Plan only when, under these rules, it is secondary to that other Plan .

When there is a basis for a Claim under This Plan and another Plan, This Plan is a Secondary Plan that has its benefits determined after those of the other Plan, unless:

- (a) the other Plan has rules coordinating its benefits with those of This Plan; and
- (b) both those rules and This Plan's rules, as described below, require that This Plan's benefits be determined before those of the other Plan.

Rules

This Plan determines its order of benefits using the first of the following rules which applies:

- (a) Nondependent/Dependent Rule. The benefits of the Plan that covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan that covers the person as a dependent.
- (b) Longer/Shorter Length of Coverage Rule. The benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan that covered that person for the shorter time.

To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new Plan does not include: (a) a change in the amount or scope of a Plan's benefits; (b) a change in the entity which pays, provides or administers the Plan's benefits; or (c) a change from one type of Plan to another. The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

Effect on the Benefits of This Plan When it is Secondary

The benefits of This Plan will be reduced when it is a Secondary Plan so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than the total Allowable Expenses, not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the Claim is made. As each Claim is submitted, This Plan determines its obligation to pay for Allowable Expenses based on all Claims that were submitted up to that point in time during the Claim Determination Period.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. The Company has the right to decide which facts are needed. The Company may get needed facts from or give them to any other organization or person. The

Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Company any facts we need to pay the Claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable monetary value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Company is more than the Company should have paid under this COB provision, the Company may recover the excess from one or more of: (a) the persons we have paid or for whom we have paid; (b) insurance companies; or (c) other organizations.

Non-complying Plans

This Plan may coordinate its benefits with a Plan that is excess or always secondary or which uses order of benefit determination rules which are inconsistent with those of This Plan (non-complying Plan) on the following basis:

- (a) If This Plan is the Primary Plan, This Plan will pay its benefits on a primary basis;
- (b) if This Plan is the Secondary Plan, This Plan will pay its benefits first, but the amount of the benefits payable will be determined as if This Plan were the Secondary Plan. In this situation, our payment will be the limit of This Plan's liability; and
- (c) if the non-complying Plan does not provide the information needed by This Plan to determine its benefits within 30 days after it is requested to do so, the Company will assume that the benefits of the

non-complying Plan are identical to This Plan and will pay benefits accordingly. However, the Company will adjust any payments made based on this assumption whenever information becomes available as to the actual benefits of the non-complying Plan.

STATE EXCEPTIONS

If you reside in the state of FLORIDA Form SRTC-2200 FL:

1. The Arbitration provision is amended to read:
ARBITRATION - Notwithstanding anything in the Group Policy to the contrary, any claim arising out of or relating to this contract, or its breach, may be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial rules except to the extent provided otherwise in this clause. Judgment upon the award rendered in such arbitration may be entered in any court having jurisdiction thereof. Any arbitration will be by mutual agreement by all parties. All fees and expenses of the arbitration shall be borne by the parties equally.

However, each party will bear the expense of its own counsel, experts, witnesses, and preparation and presentation of proofs. The arbitrators are precluded from awarding punitive, treble or exemplary damages, however so denominated. If more than one Insured is involved in the same dispute arising out of the same Group Policy and relating to the same loss or claim, all such Insureds will constitute and act as one party for the purposes of the arbitration. Nothing in this clause will be construed to impair the rights of the Insureds to assert several, rather than joint, claims or defenses

If you reside in the state of GEORGIA Form SRTC 2200 (GA):

1. The second paragraph on page 1 is amended to read:
This Policy is issued in consideration of the enrollment form and payment of any premium due. All statements in the enrollment forms are representations and not warranties. Only statements contained in a written enrollment form will be used to cancel insurance, reduce benefits or defend a claim. The entire coverage will be cancelled, if before, during or after a Loss, any material fact or circumstance relating to this insurance has been concealed or materially misrepresented.

If you reside in the state of HAWAII Form SRTC-2200-HI:

1. In the section entitled General Provisions, the provision entitled "Arbitration" is deleted in its entirety.
2. In the section entitled LIMITATION AND EXCLUSIONS, the exclusions related to 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 or Loss or damage (including death or injury) and any associated cost or expense resulting directly or indirectly from the discharge, explosion or use of any device, weapon or material employing or involving nuclear fission, nuclear fusion, or radioactive force, or chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act, regardless of any other cause or event contributing concurrently or in any other sequence thereto, are hereby deleted from the certificate.

If you reside in the state of IDAHO Form SRTC-2200-ID:

The definition of **Hospital** is amended to read:

Hospital means a provider that is a short-term, acute, general hospital that:

1. is a duly licensed institution;
2. in return for compensation from its patients, is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick person by or under supervision of Physicians;

3. has organized departments of medicine and major surgery;
4. provides 24-hour nursing service by or under the supervision of registered graduate nurses; and
5. is not other than incidentally: a) a skilled nursing facility, nursing home, custodial care home, health resort, spa or sanatorium, place for rest, or place for the aged; b) a place for the treatment of mental illness; c) a place for the treatment of alcoholism or drug abuse, place for the provision of hospice care; or d) a place for the treatment of pulmonary tuberculosis.

If you reside in the state of KANSAS Form SRTC 2200 KS:

1. Please note that: **THIS IS A LIMITED POLICY - READ IT CAREFULLY**
2. The definition of Family Member is amended by deleting the reference to Traveling Companion.
3. The provision entitled "Subrogation" does not apply to medical or dental expense benefits payable under the policy.
4. The provision entitled "Legal Actions" is amended to read: **LEGAL ACTIONS** - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives proof of Loss. No legal action for a claim can be brought against the Company more than five (5) years after the time required for giving proof of Loss.
5. The "Payment of Claims" provision is amended to state: The Company or its designated representative will pay the claim immediately after receipt of due and acceptable proof of Loss.
6. The provision entitled "Arbitration" is amended to read: After a dispute has arisen, an appraisal or arbitration may take place if You and the Company fail to agree on the amount of the Loss. However, an appraisal or arbitration will take place only if both You and the Company agree, voluntarily, to have the Loss appraised or arbitrated.

If you reside in the state of LOUISIANA Form SRTC 2000 (LA) 07/04:

1. This policy is an Individual Policy underwritten by Nationwide Mutual Fire Insurance Company.
2. **INSURANCE WITH OTHER INSURERS:** If there be other valid coverage, not with this Company, providing benefits for the same Loss on a provision of service basis or on an expense incurred basis and of which this Company has not been given written notice prior to the occurrence or commencement of Loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the Loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same Loss of which this insurer had notice bears to the total like amounts under all valid coverages for such Loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken, as the amount which the services rendered would have cost in the absence of such coverage.
3. In the **GENERAL DEFINITIONS** section:
 - a. The following is amended to read as follows:
"Bodily Injury means identifiable physical injury which: (a) is caused by an Accident, and (b) solely and independently of any other cause, except illness resulting from, or medical or surgical treatment rendered necessary by such injury, is the direct cause of Your death or dismemberment within twelve months from the date of the Accident."
4. In the **GENERAL PROVISIONS** section:
 - a. The **VALUATION** section is amended to read as follows:
 "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 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."
 - b. The **DISAGREEMENT OVER SIZE OF LOSS** shall read as follows:
 "If there is a disagreement about the amount of the Loss either You or the Company can make a written demand for an appraisal. After the demand, You and the Company will each select Your Loss. If they do not agree, they will select an arbitrator. The appraisal will set the amount of the Loss. The appraiser selected by You is paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process."
5. The start of the **ACCIDENTAL DEATH AND DISMEMBERMENT** section shall read as follows:
 "The Company will pay the percentage of the Principal Sum shown in the Table of Losses when You, as a result of an Accidental Injury occurring during the Covered Trip, sustain a Loss shown in the Table below. The Loss must occur within 180 days after the date of the Accident causing the Loss. The Principal Sum is shown on the Confirmation of Coverage. 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."
6. In **EMERGENCY SICKNESS MEDICAL EXPENSE:**
 - a. Section (b) had been amended to read:
 "(b) charges for Hospital confinement and use of operating rooms; Hospital or ambulatory medical-surgical center services (this will also include expenses for a cruise ship cabin or hotel room, not already included in the cost of Your Covered Trip, if recommended as a substitute for a hospital room for recovery from a Sickness."
 - b. The following is added:
 "(f) emergency dental treatment for the relief of pain."
7. In **EMERGENCY ACCIDENT MEDICAL EXPENSE:**
 - a. Section (b) has been amended to read:
 "(b) charges for Hospital confinement and use of operating rooms; Hospital or ambulatory medical-surgical center services (this will also include expenses for a cruise ship cabin or hotel room, not already included in the cost of Your Covered Trip, if recommended as a substitute for a hospital room for recovery from a Sickness."
 - b. The following has been added:
 "(f) emergency dental treatment for the relief of pain."
8. In the **BAGGAGE/PERSONAL EFFECTS** section, under the "Company will pay the lesser of the following," point (a) is amended to read:
 "(a) Actual Cash Value at time of Loss, theft or damage to baggage and personal effects, as determined by the Company."
9. In the **COLLISION DAMAGE WAIVER** section, point (b) is amended to read:
 "(b) the purchase price less depreciation."
10. Under **LIMITATIONS AND EXCLUSIONS:**
 - a. Point 4 shall read:
 "4. war or act of war (whether declared or not)."
 - b. The following is added:
 "26. This Policy does not insure against Loss or damage (including death or injury) and any associated cost or expense resulting directly or indirectly from the discharge, explosion or use of any device, weapon or material employing or involving nuclear fission, nuclear fusion or radioactive force, or chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act, regardless of any other cause or event contributing concurrently or in any other sequence thereto."
 - c. In the "Any Loss caused by or resulting from the following is excluded" section the following is added:
 "Radioactive contamination."

If you reside in the state of MICHIGAN Form SRTC 2700 MI:

1. The Legal Actions section under General Provisions in the Policy will read as follows:

No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives proof of Loss. No legal action for a claim can be brought against the Company more than two (2) years after the time required for giving proof of Loss unless otherwise required by law.

If you reside in the state of MISSOURI Form SRTC-2200 MO:

1. In the Definitions Section:

The definition of Accidental Injury is amended to read: **Accidental Injury** means Bodily Injury caused by an accident being the direct and independent cause in the Loss.

The definition of Hospital is amended to read: **Hospital** means a facility that:

- (a) holds a valid license if it is required by the law;
- (b) operates primarily for the care and treatment of sick or injured persons as in-patients;
- (c) has a staff of one or more Physicians available at all times;
- (d) provides 24 hour nursing service and has at least one registered professional nurse on duty or call;
- (e) has organized diagnostic and surgical facilities, either on the premises or in facilities available to the hospital on a pre-arranged basis; and
- (f) is not, except incidentally, a clinic, nursing home, rest home, or convalescent home for the aged, or similar institution.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

The definition of Pre-existing Condition is amended to read: **Pre-Existing Condition** means any injury, sickness or condition of You, or Your Traveling Companion for which within the sixty (60) day period prior to the effective date of Trip Cancellation coverage under the Group Policy such person received diagnosis or treatment for such injury, sickness or condition.

The Pre-Existing Conditions exclusion is waived for You if You enroll in the Group Policy at the time You pay the deposit required for Your Trip (or within 21 days of the initial deposit) and You purchased the coverage under the Group Policy for the full cost of their Trip.

2. The Subrogation provision and the Arbitration provision are deleted in their entirety.

3. With regard to the medical expense and Accidental Death and Dismemberment Benefits, the Legal Actions provision is amended to read:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving proof of Loss.

With regard to all other benefits, the Legal Actions provision is amended to read:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives proof of Loss. No legal action for a claim can be brought against the Company more than ten (10) years after the time required for giving proof of Loss.

4. The section entitled Limitations and Exclusions is amended as follows: The exclusions related to 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 or Loss or damage (including death or injury) and any associated cost or expense resulting directly or indirectly from the discharge, explosion or use of any device, weapon or material employing or involving nuclear fission, nuclear fusion or radioactive force, or chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act, regardless of any other cause or event contributing concurrently or in any other sequence thereto are amended so that they do not apply if considered a Terrorist Act.

5. With regard to medical expenses, the Payment of Claims provision is amended by the addition of the following provision:

If You utilize a public hospital or clinic, and such hospital or clinic submits a claim for benefits, whether or not such person has made an assignment of benefits, the Company will pay the benefits provided by the policy directly to the hospital or clinic. If, however, a claim for benefits provided by the policy is paid and then such public hospital or clinic files a claim for benefits, the Company will not be liable for the duplicate payment of such benefits to such hospital or clinic.

6. With regard to Proofs of Loss for the medical expense and Accidental Death and Dismemberment benefits, the provision is amended to read:

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

With regard to all other benefits, the Proofs of Loss Provision is amended to read:

PROOF OF LOSS - You must furnish the Company, or its designated representative, with proof of Loss. This must be a detailed sworn statement. It must be filed with the Company, or its designated representative within ninety (90) days from the date the Company requests such proof of Loss. Failure to comply with these conditions shall invalidate any claims under the Group Policy. However, no claim will be denied based upon Your failure to provide notice within the specified time frame, unless this failure operates to prejudice the Company's rights, as per 20CSR100-1.020.

If you reside in the state of MINNESOTA Form SRTC 2200 (MN):

1. The definition of Pre-existing Condition is amended so that the phrase: "or exhibited symptoms which would have caused one to seek diagnosis, care or treatment" in item (a) does not apply to the section Emergency Accident & Sickness Medical Expense provided under this Plan.

2. In the section entitled "General Exclusions"

a. The following exclusion: "being under the influence of drugs or intoxicants unless prescribed by a licensed Physician" is amended for the following benefits only: Emergency Accident & Sickness Medical Expense and Accidental Death & Dismemberment (24 Hour) to read as follows: "substance abuse and related illnesses and intoxication (blood alcohol level over the legal limit) while operating a motorized vehicle." The exclusion remains as stated under General Exclusions for all other benefits.

b. The following exclusion: "participating in bodily contact sports;" includes the following: "Bodily contact sports means any sport where the objective is to physically render an opponent unable to continue with the competition such as boxing and full contact karate".

3. In the General Provisions section, the provision entitled "Payment of Claims" is amended by the addition of the following sentence: The Company will pay the claim within 5 business days after agreement with You as to the amount of Loss.

4. In the General Provisions section, the provision entitled "Subrogation" is amended by the addition of the following sentence: The Company's rights do not apply against any person insured under this or any other policy/coverage part the Company issues with respect to the same occurrence or Loss.

5. In the General Provisions section, the provision entitled "Notice of Claim" is amended to provide for oral notification of claims, Losses, or suits under the policy.

If you reside in the state of MISSISSIPPI Form SRTC-2200 MS:

1. A provision entitled **TIME OF PAYMENT OF CLAIM** is amended to read:

Benefits payable for any Loss will be paid within 35 days after receipt of due written proof of such Loss. Benefits due are overdue if not paid within 35 days after the Company or We receive proof of Loss and the necessary information to adjudicate the claim and the necessary medical information and other information essential for Us to administer any coordination of benefits and subrogation provisions. If such information is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within 35 days after the Company receives such proof. Any part or all of the remainder of the claim that is later supported by such proof is overdue if not paid within 35 days after the Company receives such proof. To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last know address of the claimant or beneficiary in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery.

If the claim is not denied for valid and proper reasons by the end of such period of 35 days, the Company must pay You interest on accrued benefits at the rate of one and one-half percent (1 ½ %) per month on the amount of such claim until it is finally settled or adjudicated.

In the event the Company fails to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest that may accrue as provided above and any other damages as may be allowable by law.

2. The provision entitled **Physical Examination and Autopsy** is re-titled **Physical Examination** and amended to read:

Physical Examination: The Company has the right to physically examine You as often as reasonably needed while a claim is pending. The Company will bear all costs for this.

3. The provision entitled Subrogation is amended to read:
SUBROGATION - To the extent the Company pays for a Loss suffered by You, the Company will take over the rights and remedies You had relating to the Loss. This is known as subrogation. You must help the Company to preserve its rights against those responsible for the Loss. This may involve signing any papers and taking any other steps the Company may reasonably require. If the Company takes over Your rights, You must sign an appropriate subrogation form supplied by the Company. No subrogation will occur until You have been made whole for Your damages.

If you reside in the state of MONTANA Form SRTC 2200-MT:

1. The definition of sickness is amended to read:
Sickness means an illness or disease, including pregnancy, that is diagnosed or treated by a Physician after the effective date of insurance and while You are covered under the Group Policy.
2. The provision entitled Controlling Law is amended to read:
Conformity with Montana statutes: The provisions of this certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this certificate.
3. The exclusion related to pregnancy and childbirth is deleted in its entirety.

If you reside in the state of NEVADA Form SRTC-2200-NV:

1. For effective dates of coverage and termination dates of coverage, the references to 12:01 A.M and 11:59 PM are amended to read "12:00 midnight".
2. The definition of Pre-existing Condition is amended to read:
Pre-Existing Condition means any injury, sickness or condition of You, Your Traveling Companion, for which, within the 60 day period prior to the effective date of Trip Cancellation coverage under the Group Policy, medical advice, diagnosis, care or treatment was recommended or received. Such an Injury or Sickness will continue to be a Pre-Existing Condition until the expiration of 12 consecutive months, beginning with the effective date of coverage.
The Pre-Existing Conditions exclusion is waived for You if You enroll in the Group Policy at the time You pay the deposit required for Your Trip (or within 21 days of the initial deposit) and You purchase the coverage under the Group Policy for the full cost of Your Trip.

If you reside in the state of NEW JERSEY Form SRTC 2500 IL:

1. This policy is underwritten by Nationwide Life Insurance Company

If you reside in the state of NEW MEXICO Form SRTC-2200-NM:

1. The definition of Physician is amended to read:
Physician means a licensed practitioner of the healing arts acting within the scope of his/her license. The treating Physician may not be You, a Traveling Companion or a Family Member.
2. The provision entitled Arbitration is deleted in its entirety.

If you reside in the state of NORTH CAROLINA Form SRTC-2200-NC:

1. The provision entitled Arbitration is amended to read:
ARBITRATION - Notwithstanding anything in the Group Policy to the contrary, any claim arising out of or relating to this contract, or its breach, will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial rules except to the extent provided otherwise in this clause. Arbitration will take place in the county and state where You reside, unless otherwise agreed to by you and the Company. All fees and expenses of the arbitration shall be borne by the parties equally.
However, each party will bear the expense of its own counsel, experts, witnesses, and preparation and presentation of proofs. The arbitrators are precluded from awarding punitive, treble or exemplary damages, however so denominated. If more than one Insured is involved in the same dispute arising out of the same Group Policy and relating to the same Loss or claim, all such Insureds will constitute and act as one party for the purposes of the arbitration. Nothing in this clause will be construed to impair the rights of the Insureds to assert several, rather than joint, claims or defenses.
2. In the Section entitled GENERAL PROVISIONS, the following apply to the Accidental Death & Dismemberment, Air Common Carrier Accidental Death & Dismemberment, Emergency Sickness Medical Expense, and Emergency Accident Medical Expense Benefits:
 - a. "Legal Actions" is amended to read: **LEGAL ACTIONS** - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving proof of Loss.
 - b. "Proof of Loss" is amended to read: **PROOF OF LOSS** - The Claimant must send the Company, or its designated representative, proof of Loss within 180 days after a covered Loss occurs or as soon as reasonably possible.
 - c. The "Subrogation" provision does not apply to the above mentioned accident and sickness benefits.
3. In the Section entitled EXCLUSIONS, the following exclusions are deleted:
 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; and
4. The Section entitled COORDINATION OF BENEFITS is amended as follows:
 - a. Any reference to blanket insurance is deleted from the coordination of benefits provisions.
 - b. The provision entitled "Right of Recovery" is deleted in its entirety.

If you reside in the state of NORTH DAKOTA Form SRTC-2200-ND:

1. Under the section entitled GENERAL PROVISIONS, Arbitration and Legal Actions are amended to read:
ARBITRATION - Notwithstanding anything in the Plan to the contrary, any claim arising out of or relating to this contract, or its breach, may be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial rules except to the extent provided otherwise in this clause. Judgment upon the award rendered in such arbitration may be entered in any court having jurisdiction thereof. All fees and expenses of the arbitration shall be borne by the parties equally. Arbitration will be by mutual consent by all parties and the local courts must have jurisdiction.

However, each party will bear the expense of its own counsel, experts, witnesses, and preparation and presentation of proofs. The arbitrators are precluded from awarding punitive, treble or exemplary damages, however so denominated. If more than one Insured is involved in the same dispute arising out of the same Plan and relating to the same Loss or claim, all such Insureds will constitute and act as one party for the purposes of the arbitration. Nothing in this clause will be construed to impair the rights of the Insureds to assert several, rather than joint, claims or defenses.

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving proof of Loss.

If you reside in the state of OHIO Form SRTC-2200-OH:

1. The following Notices are added:
FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

COORDINATION OF BENEFITS

Notice: if you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the coordination of benefits section, and compare them with the rules of any other plan that covers you or your family.

- Item 2 under Part VII entitled "General Provisions Related to Insurance Benefits" is amended to read:
ARBITRATION - Notwithstanding anything in the Plan to the contrary, any claim arising out of or relating to this contract, or its breach, may be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial rules except to the extent provided otherwise in this clause. Judgment upon the award rendered in such arbitration may be entered in any Ohio court having jurisdiction thereof. All fees and expenses of the arbitration shall be borne by the parties equally. In addition, such arbitration must be by mutual consent by all parties.

Each party will bear the expense of its own counsel, experts, witnesses, and preparation and presentation of proofs. The arbitrators are precluded from awarding punitive, treble or exemplary damages, however so denominated. If more than one Insured is involved in the same dispute arising out of the same Plan and relating to the same Loss or claim, all such Insureds will constitute and act as one party for the purposes of the arbitration. Nothing in this clause will be construed to impair the rights of the Insureds to assert several, rather than joint, claims or defenses.

- The provision entitled "Legal Actions" is amended to read:
LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving proof of Loss.

- In the section entitled COORDINATION OF BENEFITS, the following changes are made:

The definition of Plan is amended to read:

"Plan" means a form of coverage with which coordination is allowed. The following will be considered in applying this COB provision.

"Plan" includes group insurance and group subscriber contract, an uninsured arrangement of group or group-type coverage, group or group-type coverage through a health insuring corporation or other prepayment, group practice or individual practice plan, group-type contracts, the amount by which group-type hospital indemnity benefits exceed one hundred dollars per day, medical benefits coverage under a group or group-type automobile "no fault" and traditional "fault" type contract, and Medicare or other governmental benefits, Medicaid or other plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

The term "plan" shall not include an individual insurance contract, whether single or family coverage, an individual subscriber contract, whether single or family coverage, an individual contract with a health insuring corporation, whether single or family coverage, an individual contract under any other prepayment, group practice or individual practice plan, whether single or family coverage, group or group-type hospital indemnity benefits of one hundred dollars per day or less, a supplemental sickness and accident policy excluded from coordination of benefits because of the limited nature of the program pursuant to law, school accident-type coverage, a state plan under Medicaid, or other plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

The definition of Allowable Expense is amended to read:

Allowable Expense is the necessary, reasonable, and customary item of expense for health care; when the item of expense is covered at least in part under any of the Plans involved.

The difference between the cost of a private hospital room and a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered both an Allowable Expense and a benefit paid.

When plans have differing allowable expenses, the larger allowable expense shall be used for purposes of coordination. When benefits paid by a primary plan are less than the allowable expenses, the secondary plan shall pay or provide its benefits toward any remaining balance otherwise payable by You. A secondary plan will not be required to make a payment of an amount that exceed the amount it would have paid if it were the primary plan, but in no event, when combined with the amount paid by the primary plan, shall payments by the secondary plan exceed 100% of the larger of the expenses allowable under the provisions of the applicable policies.

Under the section entitled "Rules", items (c) and (d):

(c) Children (Parents Divorced or Separated). If the court decree makes one parent responsible for health care expenses, that parent's plan is primary. If the court decree gives joint custody and does not mention health care, we follow the birthday rule.

(d) Children and the Birthday Rule. When your children's health care expenses are involved, we follow the "birthday rule." The plan of the parent with the first birthday in a calendar year is always primary for the children.

COORDINATION DISPUTES

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. (For health maintenance organizations, reference certificate's description of appeal procedures). If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686-1526.

- If you have a complaint related to a claim, You should contact the Company or its Agent at 1-877-878-4467. If you disagree with the company's decision, you have the right to file a complaint with the Ohio Department of Insurance, Consumer Services Division, 2100 Stella Court, Columbus, Ohio 43215-1067, (614)-644-2673, toll free in Ohio 1-800-686-1526.

If you reside in the state of OKLAHOMA Form SRTC 2200-OK:

- The following provision is added: **FRAUD STATEMENT: Warning:** Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of felony.
- In the section entitled "When Coverage Ends" the references to 11:59 PM are amended to read "12:01 A.M."
- In the section entitled "Limitations and Exclusions", the following changes are being made:
 - The exclusion related to war is amended to read: war or any act of war, whether war is declared or not while serving in military service or any auxiliary thereto;
 - The exclusion related to 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 is deleted in its entirety.

- c. The exclusion related to the discharge, explosion or use of any device, weapon or material employing or involving nuclear fission, nuclear fusion or radioactive force, or chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act, regardless of any other cause or event contributing concurrently or in any other sequence thereto is deleted in its entirety.
4. Under Trip Cancellation, Trip Interruption, Trip Delay, Emergency Evacuation, Repatriation of Remains, Baggage/Personal Effects, Baggage Delay, Optional Collision Damage Waiver:
- a. The provision entitled "Arbitration" is amended to read: **ARBITRATION** – Notwithstanding anything in the Group Policy to the contrary, any claim arising out of or relating to this contract, or its breach, may be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial rules except to the extent provided otherwise in this clause. Arbitration shall be by mutual agreement by all parties. Judgment upon the award rendered in such arbitration may be entered in any court having jurisdiction thereof. All fees and expenses of the arbitration shall be borne by the parties equally. However each party will bear the expense of its own counsel, experts, witnesses, and preparation and presentation of proofs. The arbitrators are precluded from awarding punitive, treble or exemplary damages, however so denominated. If more than one Insured is involved in the same dispute arising out of the same Group Policy and relating to the same loss or claim, all such Insureds will constitute and act as one party for the purposes of the arbitration. Nothing in this clause will be construed to impair the rights of the Insureds to assert several, rather than joint, claims or defenses.
- b. The provision entitled "Legal Actions" is amended to read: **LEGAL ACTIONS** - No legal action for a claim can be brought against the Company until six months after the Company receives proof of loss. No legal action for a claim can be brought against the Company more than two (2) years after the time required for giving proof of loss.
- c. The provision entitled Controlling Law is amended to read: **CONTROLLING LAW** - Any part of the certificate that conflicts with the state law of Oklahoma is changed to meet the minimum requirements of that law.
- d. In the section entitled "Definitions":
- i. The definition of dependent children is amended to read: **Dependent Child(ren)** means the Insured's child (or children), including an unmarried child, stepchild, legally adopted child from the moment of placement with the Insured or a child from the date of placement for adoption with the Insured or foster child who is: (1) less than age 19 and primarily dependent on the Insured for support and maintenance; or (2) who is at least age 19 but less than age 23 and who regularly attends an institution of learning an accredited school or college; and who is primarily dependent on the Insured for support and maintenance.
- ii. The definition of Family Member is clarified to include adopted children from the moment of placement for adoption with the Insured or a child from the date of placement for adoption with the Insured.
- iii. **Pre-Existing Condition** means any injury, sickness or condition of You, an Insured's Traveling Companion for which within the sixty (60) day period prior to the effective date under the Group Policy (a) first manifested itself or exhibited symptoms which would have caused one to seek diagnosis, care or treatment; (b) required taking 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; or (c) required medical treatment or treatment was recommended by a Physician. The Pre-Existing Conditions exclusion is waived for You if the Insured enrolls You in the Group Policy at the time the Insured pays the deposit required for his or her Trip (or within 21 days of the initial deposit) and the Insured purchases the coverage under the Group Policy for the full cost of their Trip.
5. Under Emergency Sickness Medical Expense, Emergency Accident Medical Expense, Optional Flight Accidental Death & Dismemberment, and Optional Accidental Death & Dismemberment:
- a. The provision entitled Legal Actions is amended to read: **LEGAL ACTIONS** – No action at law or in equity shall be brought to recover on this policy prior to the expiration of (60) days after written proof of loss has been furnished. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.
- b. The provision entitled Controlling Law is amended to read: **CONTROLLING LAW** - Any part of the certificate that conflicts with the state law of Oklahoma is changed to meet the minimum requirements of that law. Where the policy and certificate differ, the certificate will govern.
- c. The provision entitled Proof of Loss is amended to read: **PROOF OF LOSS** - The Claimant must send the Company, or its designated representative, proof of loss within ninety (90) days after a covered loss occurs. 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 given as soon as reasonably possible and in no event, except in the case of legal incapacity, later than one year from the time proof of loss is otherwise required.
- d. In the provision entitled Coordination of Benefits, the definition of plan is amended to read:
Plan means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by:
- (a) group, blanket or franchise insurance coverage,
(b) service plan contracts, group practice, individual practice and other prepayment coverage,
(c) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans, and
(d) any coverage under governmental programs, and any coverage required or provided by any statute.
(e) all group or group subscriber contracts as well as such group-type contracts as are not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization or group. Group-type contracts include individual policy forms that are utilized and whether or not the group-type coverage is designated as "franchise" or "blanket" or in some other fashion.
(f) both group and individual automobile "no fault" contracts but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis may be included.
- Plan does not include:
- (a) Individual or family policies, or individual or family subscriber contracts, except as provided in items (v) and (vi) above.
(b) Individually underwritten and issued contracts which provide a contractual right to renewal regardless of membership in or connection with any particular organization or group shall not be considered group type contracts, irrespective of the mode or channel of premium payment and regardless of any reduction in premium the covered person may receive by virtue of such method of premium collection.
(c) group or group-type hospital indemnity benefits (written on a non-expense incurred basis) of \$30 per day or less unless they are characterized as reimbursement type benefits but are designed to administer so as to give the insured the right to elect indemnity type benefits, in lieu of such reimbursement type benefits, at the time of claim. In any event, the amount of group and group-type hospital indemnity benefits which exceed \$30 per day may be construed as being included under the definition of Plan.
(d) School accident type coverages, written on either an individual, blanket, group or franchise basis should not be taken in to consideration in coordination of benefits. In this context, school accident type coverages are defined to mean coverage covering grammar school, middle school, and high school students for accidents only, including athletic injuries, either on a 24 hour basis or "to and from school" for which the parent pays the entire premium.
- e. In the provision entitled Coordination of Benefits, the provision entitled Right of Recovery is amended to read: Whenever payments which should have been made under this Plan in accordance with this section have been made under any other Plans, the insurer shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this section, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the insurer shall be fully discharged from liability under this Plan.
6. Any references to excess insurance in the medical or dental expense benefits are deleted in their entirety. The reference to EXCESS INSURANCE on page 1 does not apply to the Emergency Sickness Medical Expense, and Emergency Accident Medical Expense Benefits. The provision entitled Coordination of Benefits will apply to these benefits.

With regard to the medical and dental expense benefits and the accidental death and dismemberment benefits, the provision entitled "Arbitration" is deleted in its entirety.

If you reside in the state of OREGON Form SRTC 2000 (OR) 04/05:

1. Please note that: In Oregon this is an individual policy.

2. The exclusion "being under the influence of drugs or intoxicants unless prescribed by a licensed Physician" is amended to read as follows: "being under the influence of drugs, unless such drug is prescribed by a Physician or while intoxicated according to the legal limits where the Loss takes place."
3. Under OPTIONAL - FLIGHT ACCIDENTAL DEATH AND DISMEMBERMENT: Benefits will be paid equal to the amount purchased for accidental death or dismemberment when the You sustain Injuries resulting in any of the following Losses within 181 days from the date of the accident.
4. The COLLISION DAMAGE WAIVER benefit is deleted in its entirety
5. In the GENERAL DEFINITIONS section:
 - a. The following is amended to read as follows:
 "Bodily Injury" means identifiable physical injury which: (a) is caused by an Accident, and (b) solely and independently of any other cause, except illness resulting from, or medical or surgical treatment rendered necessary by such injury, is the direct cause of Your death or dismemberment within twelve months from the date of the Accident."
 - b. The following definitions are deleted in their entirety:
 "Eligible Person," "Exotic Vehicles," "Material Duties," "Own Occupancy," "Participating Organization," "Permanent Total Disability," "Policy," "Policyholder," and "Temporary Total Disability."
6. In the GENERAL PROVISIONS section:
 - a. Section (e) of WHEN YOUR COVERAGE ENDS is amended to read as follows:
 "(e) the time this policy terminates. If insurance was purchased prior to the date of termination, insurance will continue to the end of the Individual Coverage Term."
 - b. The ARBITRATION section has been amended to read as follows:
 "Notwithstanding anything in this Policy to the contrary, any claim arising out of or relating to this contract, or its breach, may be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial rules except to the extent provided otherwise in this clause. Judgment upon the award rendered in such arbitration may be entered in any court having jurisdiction thereof. All fees and expenses of the arbitration shall be borne by the parties equally. Binding arbitration must be by mutual agreement by all parties, must occur in Oregon and be handled according to Oregon Law. However, each party will bear the expense of its own counsel, experts, witnesses, and preparation and presentation of proofs. The arbitrators are precluded from awarding punitive, treble, or exemplary damages, however so denominated."
 - c. The DISAGREEMENT OVER SIZE OF LOSS section has been amended to read as follows:
 "If there is a disagreement about the amount of the Loss either You or the Company can make a written demand for an appraisal. Such appraisal must be my mutual agreement by all parties to be binding, must occur in Oregon and be handled according to Oregon law. After the demand, you and the Company will each select Your 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 You is paid by You. They Company will pay the appraiser they choose. You will share equally with the Company the cost of the arbitrator and the appraisal process."
7. Under the ACCIDENTAL DEATH AND DISMEMBERMENT benefit, the reference to "180 days" is amended to state "181 days."
8. Under the EMERGENCY SICKNESS MEDICAL EXPENSE benefit:
 - a. Section (b) is amended to read as follows:
 "(b) charges for Hospital confinement and use of operating rooms. Hospital or ambulatory medical-surgical center services (this will also include expenses for a cruise ship cabin or hotel room, not already included in the cost of Your Covered Trip, if recommended as a substitute for a hospital room for recovery from a Sickness."
 - b. The following is added:
 "(f) emergency dental treatment for the relief of pain."
9. Under the EMERGENCY ACCIDENT MEDICAL EXPENSE benefit:
 - a. Section (b) is amended to read as follows:
 "(b) charges for Hospital confinement and use of operating rooms. Hospital or ambulatory medical-surgical center services (this will also include expenses for a cruise ship cabin or hotel room, not already included in the cost of Your Covered Trip, if recommended as a substitute for a hospital room for recovery from an Injury."
 - b. The following is added:
 "(f) emergency dental treatment for the relief of pain."
10. Under LIMITATIONS AND EXCLUSIONS:
 - a. Item (10) is amended to read as follows:
 "(10) being under the influence of drugs, unless such drug is prescribed by a Physician or while intoxicated according to the legal limits where the Loss takes place unless results in the death of a non-traveling immediate Family Member."
 - b. Item (19) is deleted in its entirety.
 - c. After the phrase, "Any Loss caused by or resulting from the following is excluded," the following is added:
 "6. radioactive contamination"
11. The COORDINATION OF BENEFITS section is deleted in its entirety.

If you reside in the state of PENNSYLVANIA Form SRTC-2200-PA:

1. With regard to the Accidental Death and Dismemberment Benefit, the second sentence of the first paragraph is amended to read:
 With the exception of Loss of life, the Loss must occur within 180 days after the date of the Accident causing the Loss. For Loss of life, the death must be directly caused by an Accident that occurs while insurance under the policy is in effect.

If you reside in the state of RHODE ISLAND Form SRTC-2200-RI:

1. Under the section entitled GENERAL PROVISIONS, the provision entitled "Arbitration" is deleted in its entirety.
2. Under the section entitled GENERAL PROVISIONS, the provisions entitled proofs of Loss are amended to read: PROOF OF LOSS - The Claimant must send the Company, or its designated representative, proof of Loss within ninety (90) days after a covered Loss occurs. 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 and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

If you reside in the state of SOUTH CAROLINA Form SRTC-2200-SC: (for Emergency Accident Medical Expense, Emergency Sickness Medical Expense, Accidental Death and Dismemberment benefits only):

1. the Excess Insurance Limitations provisions are deleted in their entirety. The reference to "Excess Insurance" on page 1 is deleted.
2. The Legal Action provision is amended to read:
LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives proof of Loss. No legal action for a claim can be brought against the Company more than six (6) years after the time required for giving proof of Loss.
3. The Physical Examinations and Autopsy provision is amended to read:
Physical Examinations and Autopsy: The Company, or its designated representative, at its own expense, has the right to have You examined as often as reasonable necessary while a claim is pending. The Company, or its designated representative, also has the right to have an autopsy made at its own expense unless prohibited by law. The autopsy will be performed in South Carolina.
4. The provision entitled Arbitration is deleted in its entirety.
5. The provision entitled Subrogation is amended to read:

SUBROGATION - To the extent the Company pays for a Loss suffered by You, the Company will take over the rights and remedies You had relating to the Loss. This is known as subrogation. You must help the Company to preserve its rights against those responsible for the Loss. This may involve signing any papers and taking any other steps the Company may reasonably require. If the Company takes over Your rights, You must sign an appropriate subrogation form supplied by the Company. We may not subrogate for more than the amount of insurance benefits that We have previously paid in relation to Your Loss by the liable third party. Subrogation is not permitted if the Director of Insurance determines that the exercise of subrogation by Us is inequitable and commits an injustice to You. Attorneys' fees and costs must be paid by Us from the amounts recovered. Subrogation only applies to injury, the insured has the right to petition the Administrative Law Judge Division and it applies to liable third parties only.

6. The Definition of Pre-existing conditions is amended to read:

Pre-Existing Condition means any injury, sickness or condition of You, or Your Traveling Companion, for which within the sixty (60) day period prior to the effective date under the Group Policy such person received medical advice or treatment or medical advice or treatment was recommended.

7. The Exclusions section is amended to delete exclusions 16, 19 and 23.

8. The Coordination of Benefits Provision is amended to read:

I. COORDINATION OF BENEFITS

A. This Coordination of Benefits ("COB") provision applies to This Plan when You have health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

1. Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but
2. May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in Section IV "Effect on the Benefits of This Plan."

II. DEFINITIONS

A. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

1. Group insurance coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.
2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. "This Plan" is the part of the group contract that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan:" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

NOTE: When benefits are reduced under a Primary Plan because covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

III. ORDER OF BENEFIT DETERMINATION RULES

A. General. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

1. The other plan has rules coordinating its benefits with those of This Plan; and
 2. Both those rules and This Plan's rules, in Subsection B below, require that This Plan's benefits be determined before those of the other plan.
- B. Rules. This Plan determines its order of benefits using the first of the following rules which applies:
1. Non-Dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.
 2. Dependent Child/Parents Not Separated or Divorced. Except as stated in Paragraph (B)(3) below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents:"
 - a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
 - b. If both parents have the same birthday, the benefits of the plan which covered a parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
 - c. However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
 3. Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. First, the plan of the parent with custody of the child;
 - b. Then, the plan of the spouse of the parent with the custody of the child; and
 - c. Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III B(2).
5. (5) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored.
6. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

IV. EFFECT ON THE BENEFITS OF THIS PLAN

A. When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

B. Reduction in this Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.
3. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

V. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. Insurer has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Insurer need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Insurer any facts it needs to pay the claim.

VI. FACILITY OF PAYMENT

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, Insurer may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Insurer will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

VII. RIGHT OF RECOVERY

If the amount of the payments made by Insurer is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- A. The persons it has paid or for whom it has paid;
- B. Insurance companies; or
- C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

If you reside in the state of SOUTH DAKOTA Form SRTC 2200 SD:

In the GENERAL PROVISIONS:

1. The provision entitled Arbitration is amended to read:
ARBITRATION - Notwithstanding anything in this Policy to the contrary, any claim arising out of or relating to this contract, or its breach, may be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial rules except to the extent provided otherwise in this clause. Arbitration will be by mutual consent by all parties and any determination will not be binding on any party. Judgment upon the award rendered in such arbitration may be entered in any court having jurisdiction thereof. All fees and expenses of the arbitration shall be borne by the parties equally. However, each party will bear the expense of its own counsel, experts, witnesses, and preparation and presentation of proofs. The arbitrators are precluded from awarding punitive, treble or exemplary damages, however so denominated. If more than one Insured is involved in the same dispute arising out of the same Plan and relating to the same Loss or claim, all such Insureds will constitute and act as one party for the purposes of the arbitration. Nothing in this clause will be construed to impair the rights of the Insureds to assert several, rather than joint, claims or defenses.
2. The provision entitled Disagreement Over Size of Loss is amended to read:
DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the Loss either You or the Company may make a written demand for an appraisal. After the demand, You and the Company will each select Your 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 You is paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process. Such action must be mutually agreed to by all parties and any determination made is not binding on either party.
3. The provision entitled "Legal Actions" is amended to read:
LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives proof of Loss. No legal action for a claim can be brought against the Company more than six (6) years after the time required for giving proof of Loss.

Under the EMERGENCY SICKNESS MEDICAL EXPENSE provision, the first paragraph is amended to read:

The Company will pay benefits up to the maximum shown on the Confirmation of Coverage, if You incur Covered Medical Expenses as a result of Emergency Treatment of a Sickness that manifests itself during the Trip.

The paragraph under the EMERGENCY SICKNESS MEDICAL EXPENSE provision that begins with "If You are hospitalized due to a Sickness" is amended to read: "If You are hospitalized due to a Sickness (which occurred during the course of the scheduled Trip) beyond the date of the Scheduled Return Date, coverage will be extended until You are released from the Hospital or until maximum benefits under this Policy have been paid."

The paragraph under the EMERGENCY ACCIDENT MEDICAL EXPENSE provision that begins with "If You are hospitalized due to an Accidental Injury" is amended to read: If You are hospitalized due to an Accidental Injury (which occurred during the course of the scheduled Trip) beyond the date of the Scheduled Return Date, coverage will be extended until You are released from the Hospital or until maximum benefits under this Policy have been paid.

Under the section entitled LIMITATIONS AND EXCLUSIONS:

Exclusion 10 is amended to read: "10. being under the influence of drugs or intoxicants, unless prescribed by a Physician and only if You are committing felony at the time of the Loss unless results in the death of a non-traveling immediate Family Member."

If you reside in the state of TENNESSEE Form SRTC 2200-TN:

1. In the section entitled DEFINITIONS, the following definitions are amended to read:
Bodily Injury means identifiable physical injury which: (a) is caused by an Accident; (b) solely and independently of any other cause, except illness resulting from, or medical or surgical treatment rendered necessary by such injury, is the direct cause of Your death or dismemberment within twelve months from the date of the Accident; and (c) is not a Pre-existing Condition.
Pre-Existing Condition means, regardless of the cause of the condition, any injury, sickness or condition of Yours, Your Traveling Companion for which, within the sixty (60) day period prior to the effective date of Trip Cancellation coverage under the Group Policy, such person: (a) received or had recommended medical advice, diagnosis, care, or treatment for such condition, injury or sickness; or (b) required taking 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.
The Pre-Existing Conditions exclusion is waived for You if You enroll in the Group Policy at the time You pay the deposit required for Your Trip (or within 21 days of the initial deposit) and You purchase the coverage under the Group Policy for the full cost of Your Trip.
Sickness means: (a) an illness or disease which is diagnosed or treated by a Physician after the effective date of insurance and while You are covered under the Group Policy; and (b) is not a Pre-existing Condition.
2. In the Section entitled GENERAL PROVISIONS, the provision entitled Arbitration is amended to read:

ARBITRATION - Notwithstanding anything in the Group Policy to the contrary, any claim arising out of or relating to this contract, or its breach, will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial rules except to the extent provided otherwise in this clause. Judgment upon the award rendered in such arbitration may be entered in any court having jurisdiction thereof. All fees and expenses of the arbitration shall be borne by the parties equally.

However, each party will bear the expense of its own counsel, experts, witnesses, and preparation and presentation of proofs. If more than one Insured is involved in the same dispute arising out of the same Group Policy and relating to the same Loss or claim, all such Insureds will constitute and act as one party for the purposes of the arbitration. Nothing in this clause will be construed to impair the rights of the Insureds to assert several, rather than joint, claims or defenses.

3. In the Accidental Death and Dismemberment Benefits, the following sentence is deleted in its entirety:
The maximum benefits for any one single Accident is limited to \$15,000,000 for all persons insured under the Group Policy.
4. The medical expense benefit(s) are amended to include the following sentence:
The Company will pay for covered medical expenses incurred by You within one year from the date of Injury or Sickness provided initial treatment was received during the Trip. The Injury must occur or Sickness must begin while You are covered by the policy

If you reside in the state of TEXAS Form SRTC 2200 TX:

1. In the provision entitled **WHEN YOUR COVERAGE ENDS**, the following sentence is added:
Coverage will not end solely because a person becomes an elected official in Texas.
2. In the provision entitled **LEGAL ACTIONS** in the **GENERAL PROVISION**, the reference to "2 years" is amended to read "2 years and one day".
3. The provision entitled **NOTICE OF CLAIM** in the **GENERAL PROVISIONS** is amended by the addition of the following paragraphs:
The Company shall, not later than the 15th day after receipt of such notice of a claim:
 - a. acknowledge receipt of the claim;
 - b. commence any investigation of the claim; and
 - c. request from the Claimant all items, statements, and forms that the Company reasonably believes, at that time, will be required from the claimant. Additional requests may be made if during the investigation of the claim such additional requests are necessary.If the acknowledgement of the claim is not made in writing, the insurer shall make a record of the date, means, and content of the acknowledgement. The Company shall notify a claimant in writing of the acceptance or rejection of the claim not later than the 15th business day after the date the Company receives all items, statements, and forms required by the Company, in order to secure final proof of Loss. If the company rejects the claim, the Company will inform the Claimant of the reasons for the rejection. If the Company is unable to accept or reject the claim within 15 business days after the date the Company receives all items, statements, and forms required by the Company, the Company shall notify the claimant within such 15 business day period. The notice provided must give the reasons that the Company needs additional time. Not later than the 45th day after the date the Company notifies a Claimant of the need for additional time to investigate a claim, the Company shall accept or reject the claim. Except as otherwise provided, if the Company delays payment of a claim following its receipt of all items, statements, and forms reasonably requested and required for more than 60 days, the Company shall pay, in addition to the amount of the claim, 18 percent per annum of the amount of such claim as damages, together with reasonable attorney fees. If suit is filed, such attorney fees shall be taxed as part of the costs in the case.
4. The provision entitled **PAYMENT OF CLAIM** in the **GENERAL PROVISION** is amended by the addition of the following paragraph:
If the Company notifies a claimant that the insurer will pay a claim or part of a claim, the Company shall pay the claim not later than the fifth business day after the notice has been made. If payment of the claim or part of the claim is conditioned on the performance of an act by the claimant, the Company shall pay the claim not later than the fifth business day after the date the act is performed.
5. The **PROOF OF LOSS** provision in the **GENERAL PROVISIONS** is amended to read:
The Claimant must send the Company, or its designated representative, proof of Loss within ninety-one (91) days after a covered Loss occurs or as soon as reasonably possible.
6. The following provision is added to the policy: You may cancel the policy by giving the Company or its agent written notice within either 10 days from the date of issuance of Your policy, or Your Departure Date, whichever occurs first. If You do this, the Company will refund Your plan cost in full, excluding the administrative fee.

If you reside in the state of UTAH Form SRTC 2200 (UT):

1. In the General Provisions section, both provisions entitled Proof of Loss are deleted and replaced with the following:
PROOF OF LOSS - The Claimant must send the Company, or its designated representative, proof of Loss within ninety (90) days after a covered Loss occurs or as soon as reasonably possible.
2. In the section entitled Limitations and Exclusions, the exclusions related to excluding Loss or damage (including death or injury) and any associated cost or expense resulting directly or indirectly from the discharge, explosion or use of any device, weapon or material employing or involving nuclear fission, nuclear fusion or radioactive force, or chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act, regardless of any other cause or event contributing concurrently or in any other sequence thereto or Losses 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 are not excluded to the extent that they are caused by terrorism.

If you reside in the state of VERMONT Form SRTC-2200 VT P&C:

In the **GENERAL PROVISIONS** section, the first sentence of the provision entitled "When Your Coverage Ends" is amended to read:

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:

1. The following disclosure is added to the certificate:
THIS TRAVEL PROGRAM IS A LIMITED BENEFIT PROGRAM. READ YOUR CERTIFICATE CAREFULLY.
2. This endorsement is part of the certificate to which it is attached and provides benefits under the certificate for parties to a civil union. Vermont law requires that insurance policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this endorsement, the civil union must be established in the state of Vermont according to Vermont law.
It is understood that policy definitions and provisions designating
 - an insured
 - named insured
 - who is insured
 - who is a named insured
 - covered person(s)
 - you and/or your
 - spouse
 - family member

and any other policy or certificate definitions and provisions designating an insured under this certificate, are amended, wherever appearing, where terms denoting a marital relationship or family relationship arising out of a marriage are used, to indicate parties to a civil union and their families under Vermont law.

3. The provision entitled "Arbitration" is amended to read:
ARBITRATION - Notwithstanding anything in the Group Policy to the contrary, any claim arising out of or relating to this contract, or its breach, may be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial rules except to the extent provided otherwise in this clause. All parties must mutually agree to such arbitration. Judgment upon the award rendered in such arbitration may be entered in any court having jurisdiction thereof. All fees and expenses of the arbitration shall be borne by the parties equally.

However, each party will bear the expense of its own counsel, experts, witnesses, and preparation and presentation of proofs. The arbitrators are precluded from awarding punitive, treble or exemplary damages, however so denominated. If more than one Insured is involved in the same dispute arising out of the same Group Policy and relating to the same Loss or claim, all such Insureds will constitute and act as one party for the purposes of the arbitration. Nothing in this clause will be construed to impair the rights of the Insureds to assert several, rather than joint, claims or defenses.

4. The following items apply to the Accidental Death and Dismemberment and Medical Expense benefits ONLY:

a. The definition of Accidental Injury is amended to read:

Accidental Injury means Bodily Injury caused by an accident being the direct and independent cause in the Loss.

b. The section entitled exclusions is amended to read: (4) Exclusions:

With regard to the Accidental Death and Dismemberment benefits and the Accident and Sickness Medical Expense benefits, if provided, no benefits are payable due to Loss caused by or resulting from:

1. Pre-Existing Conditions, as defined in the Definitions section unless the insurance is purchased within 21 days of the initial Trip deposit
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;
3. Intentionally self-inflicted injuries;
4. War, invasion, acts of foreign enemies, hostilities between nations (whether declared or not), civil war;
5. Participation in any military maneuver or training exercise any Loss starting while You are in the service of the armed forces of any country. Orders to active military service for training purposes of two 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 You pro-rata any premium paid, less any benefits paid, for any period during which You are in such service;
6. Piloting or learning to pilot or acting as a member of the crew of any aircraft;
7. Participation as a professional in athletics;
8. Being under the influence of drugs or intoxicants, unless prescribed by a Physician unless results in the death of a non-traveling immediate Family Member;
9. Commission or the attempt to commit a criminal act;
10. Dental treatment except as a result of an injury to sound natural teeth limited to \$750;
11. Any non-emergency treatment or surgery, routine physical examinations, hearing aids, eye glasses or contact lenses;
12. Pregnancy and childbirth (except for complications of pregnancy) except if hospitalized;
13. Curtailment or delayed return for other than covered reasons;
14. Traveling for the purpose of securing medical treatment;
15. Services not shown as covered;
16. Confinement or treatment in a government Hospital; however the United States government may recover or collect benefits under certain conditions;
17. Care or treatment that is not medically necessary;
18. Care or treatment for which compensation is payable under Worker's Compensation Law, any Occupational Disease law; the 4800 Time Benefit plan or similar legislation;
19. Injury or Sickness when traveling against the advice of a Physician; or
20. 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.

If you reside in the state of VIRGINIA Form SRTC-2200 VA:

1. Under the section entitled "General Provisions" the following changes are made:

The provision entitled "Subrogation" is amended to read:

SUBROGATION - To the extent the Company pays for a Loss suffered by You, the Company will take over the rights and remedies You had relating to the Loss. This is known as subrogation. You must help the Company to preserve its rights against those responsible for the Loss. This may involve signing any papers and taking any other steps the Company may reasonably require. If the Company takes over Your rights, You must sign an appropriate subrogation form supplied by the Company. (This provision does **not** apply to the Emergency Sickness Medical Expense, and Emergency Accident Medical Expense Benefits.)

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 · Bail bond* · Lost Baggage retrieval · Inoculation information

* Payment reimbursement to the Assistance Company is Your responsibility

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)

Travel assistance services are provided by an independent organization and not by Nationwide Mutual Insurance Company, Nationwide Life Insurance Company, Nationwide Mutual Fire Insurance or Seven Corners, Inc. There may be times, when circumstances beyond the Assistance Company's control, hinder their endeavors to provide travel assistance services. They will, however, make all reasonable efforts to provide travel assistance services and help you resolve your emergency situation.

FILING A CLAIM IS SIMPLE

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

Seven Corners Administrators

303 Congressional Blvd.

Carmel, IN 46032

800-335-0477 or 317-575-2656

Fax: 317-575-2659

www.sevencorners.com

IMPORTANT: To facilitate prompt claims settlement, You will be asked to provide proof of Your loss. Therefore, be sure to obtain the following as applicable: 1.) For medical claims - detailed medical statements from treating physicians where and when the accident or Sickness occurred as well as receipts for medical services and supplies; 2.) For baggage and baggage delay claims - reports from parties responsible (i.e. airline, cruise line, etc.) for loss, theft, damage or delay. Some claims may also require a police report. Please obtain receipts for lost or damaged items; 3.) For trip delay claims - a statement from party causing delay and receipts for expenses; 4.) For cancellation/interruption claims - Your travel invoice, the cancellation or interruption date, original unused tickets/vouchers, the travel organizer's cancellation clause with regard to nonrefundable losses. You will also be asked to provide proof of payment.

No benefits will be paid for any expenses reimbursed to You or services provided to You by any other source. Benefits cannot be duplicated under Your Protection Plan.

Unless You otherwise designate a beneficiary, or in the event the designated beneficiary predeceases You, indemnity for loss of life will be paid to the first of the following surviving beneficiaries: Your spouse; child or children, jointly; parents, jointly if both are living, or the surviving parent, if only one survives; brothers and sisters jointly; or Your estate.

Protection Plan costs are non-refundable after the 10-day review period.

If You have two Protection Plans underwritten by Nationwide Mutual Insurance Company, Nationwide Life Insurance Company, or Nationwide Mutual Fire Insurance that duplicate benefits, You will be paid up to the highest benefit amount under only one Protection Plan for each Trip. The maximum benefit for Flight Accident Option is \$100,000, \$250,000, or \$500,000 for any one person at any one time.

FOR QUESTIONS AND GENERAL INFORMATION

Contact your agent or Seven Corners

Seven Corners

303 Congressional Blvd.

Carmel, IN 46032

800-335-0611 or 317-575-2652

Fax: 317-575-2659

www.sevencorners.com

Monday - Friday 8:00am - 5:00pm Indiana Time.