ARCH INSURANCE COMPANY
(A Missouri Corporation)

Home Office Address:
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Kansas City, MO 64108

Administrative Address:
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BLANKET ACCIDENT POLICY

POLICYHOLDER	AHI Travel Assurance
POLICY NUMBER	SPR4278827023
POLICY EFFECTIVE DATE	February 15, 2023
POLICYHOLDER ADDRESS	International Tower, Suite 600, 8550 W. Bryn Mawr Avenue, Chicago, IL 60631
POLICY TERM	February 15, 2023 – February 14, 2024
ASSISTANCE PROVIDER	CareFree Travel Assistance™

This Policy takes effect at 12:01 AM on the Policy Effective Date shown above at the address of the Policyholder. The Policy terminates at 12:01 A.M on the last day of the Policy Term unless the Policyholder and the Company agree to continue coverage under this Policy for an additional Policy Term. If coverage is continued for an additional Policy Term and the required premiums are paid on or before the premium date, the Company will issue a Policy to identify the new Policy Term. It continues in effect in accordance with the provisions set forth in this Policy.

The insurance provided by this Policy is limited to the amounts indicated in the Schedule, for the Covered Activities to be insured against. It is only provided with respect to the Insured in the eligible class as shown.

The Company agrees to provide insurance to the Policyholder in exchange for the payment of the required premium. The Policy contains the terms under which the Company agrees to insure and pay benefits.

This Policy is governed by the laws of the state where it was delivered.

IN WITNESS WHEREOF, Arch Insurance Company has caused this policy to be executed and attested.

Regan A. Shulman
Secretary

Brian D. First
President

THIS IS A BLANKET ACCIDENT INSURANCE POLICY.
The Policy is a legal contract between the Policyholder and Arch Insurance Company.
IT PAYS FOR SPECIFIC LOSSES FROM ACCIDENTS AND SICKNESS.
PLEASE READ THE POLICY CAREFULLY.

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SECTION I - SCHEDULE OF BENEFITS

CLASSES OF ELIGIBLE PERSONS
A person may be insured only under one Class of Eligible Persons even though he or she may be eligible under more than one class.

Class 1: All travelers participating in an AHI Travel Assurance itinerary with trip dates occurring within the Policy Period.

Covered Activity
The following are the Covered Activities for which insurance applies:

Class	**Covered Activity**
Class 1	Specified Activity

Specified Activity: While participating in an AHI Travel Assurance itinerary.

Subject to all the terms and conditions of the Policy, benefits described in the Policy are payable when an Insured suffers a Covered Loss or Injury as a result of a Covered Accident during one of the covered Activities listed above.

Schedule of Benefits:

	Maximum Benefit Amount
Accident Medical, Dental and Sickness Expense Benefit	
Total Benefit Maximum for all Accident Medical, Dental and Sickness Expense Benefits	$20,000 per Insured
Loss Period	365 day
Scope of Coverage	Full Excess
Sub-limits	
Accident Medical Maximum Benefit	$10,000 per Insured
Sickness Maximum Benefit	$10,000 per Insured
Dental Maximum Benefit	$2,500 per Insured
Trip Delay	$1,000
If Trip is delayed more than	12 Hours
Emergency Medical Evacuation & Repatriation of Mortal Remains Benefit	
Maximum Benefit per Insured	$50,000

SECTION II – DESCRIPTION OF COVERED ACTIVITIES

We will pay benefits if the Insured is engaged in one of the Covered Activities described below, as listed in the Schedule of Benefits and when the Covered Loss occurs. Unless otherwise specified, We pay benefits only once for any one Covered Loss, even if covered by more than one Covered Activity. We shall pay the single largest benefit amount applicable under all such Covered Activities.

Specified Trip Activity

We will pay benefits as shown in the Schedule of Benefits for any Covered Loss resulting directly while the Insured is engaged in this Covered Activity:

The Covered Loss must take place while:

1. traveling or making a short Trip; and
2. participating in the activity described in the Schedule of Benefits.

SECTION III - DEFINITIONS

For the purposes of this Policy, certain words with specific meanings are capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found in the Schedule of Benefits or in this Definitions Section.

ACCIDENT means a sudden, unexpected event happening by chance that arises from an external source to the Insured and occurs at an identifiable time and place.

BENEFIT PERIOD means the period of time, as stated on the Schedule of Benefits, between the date of the Accident causing the Injury for which benefits are payable and the date after which no further benefits will be paid.

COMMON CARRIER means any motorized land, water or air Conveyance, operated by an organization other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by an employee or an individual under contract.

CONVEYANCE means any motorized craft, vehicle or mode of transportation licensed or registered by a government authority with competent jurisdiction.

COVERED ACCIDENT means an Accident that occurs while coverage is in force for an Insured and for which benefits are payable.

COVERED ACTIVITY means any activity that the Policyholder requires the Insured to attend, or that is under its supervision and control listed in the Schedule of Benefits and insured under the Policy**.**

COVERED EXPENSES means expenses actually incurred by or on behalf of an Insured for Treatment, services and supplies covered by this Policy. Coverage under the Policyholder's Policy must remain continuously in force from the date of the Covered Loss until the date Treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such Treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

COVERED LOSS or COVERED LOSSES means a loss which meets the requisites of one or more benefits, results from a Covered Accident or Injury, Covered Activity or Medical Emergency, and for which benefits are payable under the Policy.

DEPENDENT means an Insured's:
1. lawful Spouse, if not legally separated or divorced,
2. children under age 26.
The age limitations will not apply to an Insured's unmarried child who is incapable of self-support due to a mental disability or physical handicap. Proof of such incapacity must be furnished to Us immediately upon enrollment or within 31 days of the child reaching the age limitation.

Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2 year period following the age limitation.

The term child as used herein means the Insured's natural child, adopted child (or child placed in the Insured's home for purposes of adoption), foster child, stepchild, or other child for whom the Insured has legal guardianship.

DOMESTIC PARTNER means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Insured and shared financial assets/obligations with the Insured. Both the Insured and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Insured nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. We require proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

EMERGENCY ROOM means a trauma center, urgent care facility or special area in a Hospital that is equipped and staffed to give people emergency Treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.

HOME COUNTRY means a country from which the Insured holds a passport. If the Insured holds passports from more than one country, his or her Home Country will be that country which the Insured has been residing for the last 12 months declared to Us in writing as his or her Home Country. For United States passport holders, residents of Puerto Rico, Guam, Northern Mariana Islands, Saipan, and US Virgin Islands travelling/visiting any US state or District of Columbia are considered outside of their home country.

HOSPITAL means an institution that:

1) operates as a Hospital pursuant to law for the care, Treatment and providing in-patient services for sick or Injured persons; and is a duly licensed institution, operated lawfully in its area;
2) provides 24-hour nursing service by Registered Nurses on duty or call;
3) has a staff of one or more licensed Physicians available at all times;
4) provides organized facilities for diagnosis, Treatment and surgery, either
   a) on its premises; or
   b) in facilities available to it, on a pre-arranged basis;
5) is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
6) is not a facility for the Treatment of drug addiction, alcoholism, Treatment of the aged.

We will not deny a claim for services rendered in a Hospital having one or more of the following accreditations solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the Treatment of a physical disability:

1) the Joint commission of Accreditation of Hospitals; or
2) the American Osteopathic Association; or
3) the Commission on the Accreditation of Rehabilitative Facilities.

HOSPITAL CONFINED means a stay of 24 or more consecutive hours as a registered resident bed-patient in a Hospital.

HOST COUNTRY means a country or territory the Insured is visiting or in which the Insured is living which is not his/her Home Country

IMMEDIATE FAMILY means the Insured's parent, legal guardian, grandparent, Spouse, child(ren) (includes legally adopted or step child(ren), brother, sister, grandchild(ren), or in-laws.

INJURY or INJURED means bodily injury caused by the direct result of an Accident occurring while the Policy is in force as to the person whose injury is the basis of the claim which results directly from a Covered Loss.

INSURED means an eligible person who is within the covered class(es) listed in the Policy, and for whom the required premium is paid when due.

MEDICAL EMERGENCY means a condition which meets all of the following criteria:

1) there is present a severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Insured's condition or place his or her life in jeopardy;

2) the severe or acute symptom occurs suddenly and unexpectedly; and
3) the severe or acute symptom occurs while the Policy is in force as to the person suffering the symptom and under the circumstances described in a Covered Activity:
   a) applicable to that person; and
   b) to which this Policy applies.

MEDICALLY NECESSARY means a determination by the Insured's Physician that Treatment, service or supply provided to treat an Injury Medical Emergency is:
1) appropriate and consistent with the diagnosis and does not exceed in scope, duration, or intensity the level of care needed to provide safe, adequate, and appropriate Treatment;
2) is commonly accepted as proper care or Treatment in accordance with the medical practices of the United States and federal guidelines;
3) can reasonably be expected to result in or contribute to the improvement of the Injury or Medical Emergency; and
4) is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition of the Injury or the quality of the medical care provided.

The fact that a Physician may prescribe, order, recommend, or approve a Treatment, service or supply does not, of itself, make the Treatment, service, or supply medically necessary for the purpose of determining eligibility for coverage under this Policy.

The Physician must be acting within the scope of his/her license. A Physician does not include an Insured or any Immediate Family member.

PHYSICIAN means a licensed health care provider practicing within the scope of his or her license and rendering care and Treatment to the Insured that is appropriate for the condition and locality, and who is not:
1. the Insured;
2. Immediate Family of either the Insured or the Insured's Spouse;
3. a person living in the Insured's household; or
4. a person employed or retained by the Policyholder; or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

POLICYHOLDER means an organization as shown in the Schedule of Benefits in the Policy.

PRE-EXISTING CONDITION means an illness, disease or other condition of the Insured, that in the 2 month period before the Insured's coverage became effective under this Policy:

1. first manifested itself, worsened, became acute or exhibited symptoms that would have caused an ordinary prudent person to seek diagnosis, care or Treatment; or
2. required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or
3. was treated by a Physician or Treatment had been recommended by a Physician.

REGISTERED NURSE means a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other jurisdictional authority, and who is legally entitled to place the letters R.N. after his or her name.

SICKNESS means an illness, disease or condition that impairs an Insured's normal functioning of mind or body and which is not the direct result of an Injury or Accident. Sickness also includes complications of pregnancy.

SPOUSE means an Insured's legal Spouse. Spouse will also include a Domestic Partner or civil union partner as determined by any controlling legal authority or, in the absence of such authority, by agreement between Us and the Policyholder.

TREATMENT means medical advice, diagnosis, care or services (including diagnostic measures) received by a person, or the use of drugs or medicines by a person.

TRIP means travel by air, land, or sea from the Insured's residence or place of employment.

USUAL AND CUSTOMARY CHARGES (U&C) means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

WE, OUR, US means Arch Insurance Company or its authorized agent.

YOU, YOUR, YOURS means the Insured who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.

SECTION IV - ELIGIBILITY FOR INSURANCE

A person is eligible for insurance under this Policy when he or she meets the definition of eligible person shown in the Schedule of Benefits.

SECTION V - EFFECTIVE DATE OF INSURANCE

Policy Effective Date. This Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder.

Insured's Effective Date

An Insured's coverage under this Policy begins on the later of:
1) the Policy Effective Date; or
2) the date such person becomes eligible, subject to any required waiting period; as described in the Schedule of Benefits.

SECTION VI - TERMINATION DATE OF INSURANCE

Policy Termination Date

Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by Us will be without prejudice to any claims originating prior to the date of termination.

If this Policy terminates due to non-payment of premium, it may be reinstated if mutually agreed upon, in writing, by the Policyholder and Us. Written request for reinstatement must be made to Us within 60 days of the termination date. All required premiums must be paid prior to reinstatement.

This Policy terminates automatically on the earlier of:
1) The Policy Termination Date shown in this Policy; or
2) The premium due date if premiums are not paid when due; subject to the grace period provided in the section of this Policy entitled Premium.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to Us to terminate this Policy on the last day of the period for which premiums have been paid.

We and the Policyholder may terminate this Policy at any time by written mutual consent.

Insured's Termination Date

An Insured's coverage under this Policy ends on the earliest of:
1) The date this Policy terminates;
2) The date the Insured requests, in writing, that his or her coverage be terminated;
3) The date the Insured enters full-time active duty in the armed forces of any country or international authority;
4) The date the Insured ceases to be eligible as described in this Policy provided all required premiums are paid; or
5) The last day of the period for which premiums have been paid.

SECTION VII - DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. All benefits payable are shown in the Schedule of Benefits. (These benefits may vary on a class level.)

ACCIDENT MEDICAL, DENTAL, AND SICKNESS EXPENSE BENEFIT

We will pay Accident Medical, Dental and Sickness Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident or Sickness These benefits are subject to the Benefit Periods; Benefit Maximums; and other terms or limits shown in the Schedule of Benefits.

Accident Medical and Sickness Expense Benefits are only payable:

1) for Usual and Customary Charges incurred after the Deductible has been met;
2) for those Medically Necessary Covered Expenses incurred by or on behalf of the Insured;
3) for charges incurred within the timeframe shown on the Schedule of Benefits after the date of the Covered Accident or Sickness.

No benefits will be paid for any expenses incurred that are, in Our judgment, in excess of Usual and Customary Charges.

Dental expenses covered include dental x-rays for the repair or Treatment of each Injured tooth that is whole, sound and a natural tooth at the time of the Covered Accident.

Covered Medical Expenses, from a Covered Accident or Sickness, include:

1) Daily Hospital room and board expenses; the daily room rate when an Insured is Hospital Confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
2) Physician Office Visit; non-surgical Treatment or examination expenses (excluding medicines) including the Physician's initial visit; each necessary follow-up visit; and consultation visits when referred by the attending Physician.
3) Physician surgical expenses. If an injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 100% of Covered Expenses for the additional surgeries.
4) Assistant Surgeon.
5) Emergency Room or emergency care facility and Supplies expense incurred within 24 hours of a Covered Accident or Sickness and including the attending Physician's charges; x-rays; laboratory procedures; use of the Emergency Room and supplies.
6) Ambulance expenses for transportation from the emergency site to the Hospital.
7) Prescription drug expenses prescribed by a Physician.
8) Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for the Insured. We will not cover computers; motor vehicles or modifications to a motor vehicle; ramps and installation costs; eyeglasses and hearing aids.
9) Medical services and supplies for blood and blood transfusions; oxygen and its administration.

ADDITIONAL ACCIDENT BENEFITS

Trip Delay

If the Insured's Trip is delayed for the amount of hours shown in the Schedule of Benefits, we will reimburse Covered Expenses as shown on the Schedule of Benefits for Covered Expenses which include charges incurred for reasonable, additional accommodations and traveling expenses until travel becomes possible. Incurred expenses must be accompanied by receipts. This benefit is payable only for one delay of the Insured's Trip.

Trip Delay must be caused by one of the following reasons:

- Common Carrier delay;
- lost or stolen passport, travel documents or money;
- quarantine;
- Natural Disaster;
- the Insured being delayed by a traffic accident while en route to a departure;
- hijacking;
- unpublished or unannounced strike; civil disorder or commotion;
- riot.

Emergency Medical Evacuation Benefit

We will pay Covered Expenses, up to expenses incurred to the Maximum Benefit shown in the Schedule of Benefits, subject to the following conditions for emergency medical evacuation, if:

1. The Insured suffers a covered Medical Emergency resulting directly; and independently of all other causes; from a covered Medical Emergency that occurs while traveling from his or her principal residence to another city or foreign country, with at least 50 miles distance; and
2. The Insured's attending Physician certifies an emergency need to send the Insured, under medical supervision, to the nearest medical facility.

Eligible expenses include:
1. charges for ambulance services required while transporting the Insured to the nearest appropriate Treatment facility; or
2. charges for medical services required to send the Insured to the nearest appropriate Treatment facility; or
3. reimbursement of economy class Transportation charges for return of the Insured from the Treatment facility to home, paid for by the Insured within one year from the date he or she was first scheduled to return from the Trip. Any refunds paid or payable from the unused Transportation tickets will reduce benefits; or
4. charges for necessary travel expenses of an escort, that are limited to food; hotel room; and economy class Transportation charges; and

Only the charges incurred that are Medically Necessary and do not exceed the Usual and Customary Charges for similar Treatment; services; or supplies in the locality where the expense is incurred; and do not include charges that would not have been made if there were no insurance.

Benefits will not be payable unless: We authorize in writing, or by an authorized electronic means, all expenses in advance, and services are coordinated by Our Assistance Provider. The Insured must, furnish: travel invoices; medical reports; or records, or other documents. We require to determine if benefits are payable. Benefits will be paid to the party who actually paid for the expenses upon Our receipt of satisfactory proof that the expense was paid.
If the Insured pays eligible expenses for a covered Medical Emergency for which We believe a third party is liable, We will pay the benefits for Emergency Medical Evacuation. However, if the Insured recovers payment from the third party, he or she must refund to Us the lesser of:

1. the amount We paid for the eligible expenses; or
2. an amount equal to the sum received from the third party for such expenses.

Benefits will not be paid for any of the following:
1. expenses that exceed the Maximum Benefit;
2. services not pre-approved by Us, or for services performed by a vendor not authorized by Us; or
3. expenses paid or payable by any Workers' Compensation, occupational disease or similar law that would pay emergency medical evacuation expenses in the absence of this benefit.

Repatriation of Mortal Remains Benefit
We will pay Eligible Expenses, as shown in the Schedule of Benefits, incurred for the return of the Insured's remains to his or her place of residence in his or her home country and state if the Insured's death results directly; and independently of all other causes; from a Medical Emergency outside of his or her Home Country or home state or more than 50 miles from the Insured's place of residence.

Eligible Expenses means costs, pre-approved by Us and incurred for embalming; cremation; coffin or urn; transportation of the body or remains; necessary travel expenses of an escort. Necessary travel expenses are limited to food; hotel room; and economy class transportation charges.

The total of all benefits outlined in this Benefit may not exceed the Maximum Benefit Amount shown in the Schedule of Benefits

SECTION VIII – SCOPE OF COVERAGE

Benefits will be paid according to the following basis.

Full Excess Benefits
If an Insured incurs Covered Expenses, We will pay the applicable benefit, subject to any applicable Benefit Period shown on the Schedule of Benefits that are in excess of amounts payable by any other Health Care Plan; regardless of any Coordination of Benefits provision contained in such Health Care Plan. The first expense must be incurred within the Loss

Period stated on the Schedule of Benefits. The Total Benefit Maximum payable and sub-limits under the Policy are shown on the Schedule of Benefits.

Health Care Plan means any contract, policy or other arrangement for benefits or services for medical or dental care or Treatment under:
1. group or blanket insurance, whether on an insured or self-funded basis;
2. hospital or medical service organizations on a group basis;
3. Health Maintenance Organizations on a group basis;
4. group labor management plans;
5. employee benefit organization plan;
6. professional association plans on a group basis;
7. any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended; or
8. automobile no-fault coverage (unless prohibited by law).

SECTION IX - PREMIUM

We provide insurance in return for premium payments. The premium showed in the Schedule of Benefits is payable to Us in the manner described in the schedule; and is based on: rates currently in force; the plan; and the amount of insurance in force.

We have the right to rely upon the accuracy of the Policyholder's calculations; and require the Policyholder to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Policyholder will pay the additional premium or apply the premium credit at the next premium due date.

If any premium payment is not paid when due, the Policy will be cancelled as of the premium due date; except as provided under the Grace Period section.

Grace Period

After the payment of the first premium, this Policy will have a 31 day grace period. This means that if premium is not paid on or before the date it is due, it may be paid during the 31 day grace period. During this time, this Policy will stay in force provided the Policyholder pays all the premiums due by the last day of the grace period; unless the Policyholder gives Us written notice of the discontinuance of the coverage in advance of the date of discontinuance and in accordance with the terms of the Policy. This Policy will terminate on the last day of the period for which all premiums have been paid if the Policyholder fails to pay all premiums due by the last day of the grace period.

Changes in Premium Rate

We may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more than once in a 12 month period.

However, We reserve the right to change rates at any time if any of the following events occur:
1) A change in the terms of the Policy.
2) A subsidiary; division; affiliated organization; or eligible class is added or deleted to the Policy.
3) A change in any federal; or state law; or regulation affecting this Policy and Our benefit obligation.
4) A change in the factors bearing on the risk assumed.
5) A misrepresentation in the information relied on in establishing the rate for this Policy.
6) The number of Insured's or persons eligible for coverage or Estimated Volume of Insurance increases or decreases by more than 15% since the later of the Policy Effective Date or the date of the last renewal of this Policy.
7) The Policyholder fails to provide sufficient information, as required by Us to confirm adequacy and accuracy of premiums and rates being paid.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.

Premium Audit
We may examine the Policyholder's books and records relating to this Policy at any reasonable time during the Policy Term and up to three (3) years after expiration of this Policy or until final adjustment and settlement of all claims under this Policy, whichever is later.

The Policyholder must maintain information pertaining to the Insureds, but not limited to each Insured's Benefit Amount, Class, salary, enrollment form, if any, and beneficiary designations or assignments.

Reinstatement
The Policy may be reinstated within 31 days of lapse if it has lapsed for nonpayment of premium, if: the Policyholder submits written application to Us; We accept the application; and the Policyholder makes payment of all overdue premiums.

SECTION X - CLAIMS PROVISIONS

Notice of Claim
Written notice of claim; death; or injury must be given to Us or Our designated representative within 20 days after the date of the Covered Loss or as soon as reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably practicable.

Notice can be given to:

Online: www.aontravelclaim.com
Mail: Aon Affinity, 900 Stewart Avenue, Garden City, NY 11530-9998
Phone: 1-800-826-8210 or 1-516-342-2720

Notice should include the Insured's name, address, Policyholder name and Policy Number.

Claim Forms
When We receive a notice of claim, We will send forms for filing proof of loss. If claim forms are not sent within 15 days the claimant will satisfy the requirements of written proof of loss by sending the written proof as shown below. Proof of loss must describe the occurrence, extent and nature of the loss.

Proof of Loss
Written proof of loss, including a loss of time for disability, must be given to Us within 90 days after the date of the Covered Loss, or after the commencement of the period for which We are liable. If the proof of loss is not submitted within 90 days, it should be sent as soon as reasonably possible; otherwise the claim may be reduced or invalidated. In no event, except in the absence of legal capacity, should proof of loss be sent later than one year from the time proof is otherwise required. We may require subsequent proofs of loss for the continuance of the disability and these should be provided at reasonable intervals.

Beneficiary
The Insured may designate a beneficiary. The primary Insured shall have the sole right to designate a beneficiary for any Dependent child who is a minor. All beneficiary designations must be 1) in writing; 2) filed with the Policyholder; and 3) provided to Us at the time of claim; or 4) at such other time as We may require.

The Insured, and no one else, unless there is an irrevocable assignment, has the right to change the beneficiary except as set forth above. The Insured does not need the consent of anyone to do so.

All beneficiary changes must be 1) in writing; 2) filed with the Policyholder; and 3) provided to Us at the time of claim or such other time as We may require. If it is necessary to designate a beneficiary for a minor, the parent or guardian may exercise that right. The change will be effective when received by the Policyholder. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validly of a change.

Payment of Claims
We, or Our designated representative, will pay a claim after receipt of acceptable proof of loss. Benefits for loss of life are payable to the Insured's beneficiary. The designation shall be as follows:

1) Beneficiaries designated in writing by the Insured for this Policy on file with the Policyholder, if any, otherwise;
2) Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise;
3) If a beneficiary is not otherwise designated by the Insured, benefits for loss of life will be paid to the first of the following surviving preference beneficiaries surviving party in the following order:

    1) the Insured's Spouse/Domestic Partner;
    2) in equal shares to the Insured's child or children jointly;
    3) in equal shares to the Insured's surviving parents jointly if both are living or the surviving parent if only one survives;
    4) in equal shares to the Insured's surviving brothers and sisters jointly; or
    5) the Insured's estate.

All other claims will be paid to (or on behalf of, if applicable) the Insured suffering the loss. In the event the Insured is a minor, incompetent or otherwise unable to give a valid release for the claim, We may make arrangement to pay claims to the Insured's legal guardian, committee or other qualified representative. All or a portion of all other benefits provided by this Policy may, at the option of Us, be paid directly to the provider of the service(s). All benefits not paid to the provider will be paid to the Insured.

Any payment made in good faith will discharge Our liability to the extent of the claim.

Recovery of Overpayment
If benefits are overpaid; or paid in error We have the right to recover the amount overpaid; or paid in error by any of the following methods:
1) A request for lump sum payment of the amount overpaid; or paid in error; or
2) Offset or reduction of any proceeds payable under this Policy by the amount overpaid; or paid in error.

Right of Recovery
An Insured may incur charges due to an Injury for which benefits are paid by this Policy. The injury may be caused by the act or omission of another person. If so, the Insured may have a claim against that other person for payment of expense-incurred charges. If Recovery under the claim is made, the Insured must repay Us the Recovery made from: 1) another person; 2) insurance companies; or 3) other organizations.
Recovery means monies paid to the Insured through judgment, settlement or otherwise to compensate for all losses caused by the Injury.

Net Recovery means the Insured's Recovery less attorney's fees and court costs incurred in making the Recovery. Refund means repayment to Us for benefits paid.

Timely Payment of Claims
Benefits for loss covered by this Policy, other than benefits that require periodic payment, will be paid immediately after We receive due written proof of such loss. Subject to due proof of loss, all benefits for loss covered by this Policy that require periodic payment shall be paid on a monthly basis during the continuance of the period for which We are liable, and. any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

Physical Examination and Autopsy
We have the right to have a Physician of Our choice examine the Insured as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid.

We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

Subrogation
To the extent We for a loss suffered by an Insured, We will take over the rights and remedies the Insured had relating to the loss. This is known as subrogation. The Insured must help Us to preserve its rights against those responsible for the loss.

This may involve signing any papers and taking any other steps We may reasonably require. If We take over an Insured 's rights, the Insured must sign an appropriate subrogation form supplied by Us. We have the right to offset future benefits payable to the Insured under this Policy against any such Recovery.

SECTION XI - GENERAL POLICY PROVISIONS

Assignment

This Policy is not assignable, whether by operation of law or otherwise. Benefits may be assigned. No assignment of interest in loss of life benefits shall be binding on Us until the original or duplicate thereof is received by Us. We assume no responsibility for the validity of such assignment.

Clerical Error

Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by Us, will not invalidate coverage otherwise validly in force; nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to Us and is rectified promptly upon discovery. No error will continue the insurance of an Insured beyond the date it should end under the Policy terms. After an error is found, We will take appropriate action, which may include adjusting, collecting or refunding premium.

Conformity with State Laws

On the effective date of this Policy, any provision of this Policy in conflict with the laws of the state where it is issued is amended to conform to the minimum requirements of such laws.

Entire Contract/Changes

This Policy, including any endorsements; amendments; and attached papers; the signed application of the Policyholder; and any individual applications of Insured's is the entire contract between the Policyholder and Us. A copy of the application, if any, of the Policyholder shall be attached to the Policy when issued. All statements made by the Policyholder or by an Insured are in the absence of fraud, deemed representations and not warranties. No such statement will cause Us to void the insurance under this Policy or be used as a defense of a claim, unless it is contained in a written application.

An Insured, his/her beneficiary, or assignee, shall have the right to make written request to Us for a copy of such application and We shall, within 15 days after the receipt of such request at its home office or any of Our branch offices, deliver or mail to the person making such request a copy of such application. Such written request shall provide Us with the full name and address of the Insured, the policy owner and the policy number if known, or the written request shall contain such information that We can reasonably be expected to locate the application. If such copy is not so delivered or mailed, We shall be precluded from introducing such application as evidence in any action based upon or involving any statements contained therein.

Valid changes to this Policy may be made at any time by an endorsement or amendment signed by Us, provided that any such amendment which reduces or eliminates coverage was either requested in writing by the Policyholder or signed by the Policyholder. We may also, upon 31 days written notice to the Policyholder, change or modify the provisions of this Policy to comply with any applicable requirements of the Internal Revenue Service and any state or other federal law or regulation. No agent may change this Policy or waive any of its provisions.

Electronic Delivery of Documents

The Policyholder agrees to receive, accept, obtain or submit any and all documentation including the policy in electronic form e.g. via email and agrees that electronic communications is a reasonable and proper form of communication that fully satisfies any requirement that communications be provided in writing.

Insolvency

The insolvency; bankruptcy; financial impairment; receivership; voluntary plan of arrangement with creditors; or dissolution of the Policyholder will not impose upon Us any liability other than the liability defined in this Policy. The insolvency of the Policyholder will not make Us liable to the creditors of the Policyholder, including insured's under this Policy.

Incontestability

Except for nonpayment of premiums, We will not contest the validity of an Insured's coverage after it has been in force for two years from its date of issue. No statement made by an Insured relating to his or her insurability shall be used to contest

the validity of his insurance after the insurance has been in force for two years during his or her lifetime, exclusive of any period of disability; nor unless it is contained in a written application signed by him or her.

Legal Action

No legal action may be brought to recover on this Policy until there has been full compliance with all the terms of this Policy. All Policy terms will be interpreted under the laws of the state in which this Policy was issued. No legal action may be brought to recover on this Policy before 60 days following the date written Proof of Loss was given to Us. No legal action may be brought against Us more than three (3) years after the time required for written Proof of Loss.

Misrepresentation and Fraud

This entire Policy will be void, whether before or after a loss, if We determine that the Policyholder; Insured; or its agent has concealed or misrepresented any material fact or circumstance concerning this Policy, including any claim or any case of fraud by the Policyholder; Insured; Third Party Administrator; or other agent relating to this Policy.

Misstated Data

We have relied upon the underwriting information provided by the Policyholder; its Third Party Administrator; or other Agent in the issuance of this Policy. Should subsequent information become known which, if known prior to issuance of this Policy, would have affected the rates; deductibles; terms; or conditions for coverage, We will have the right to revise the rates; deductibles; terms; or conditions as of the Effective Date of issuance, by providing written notice to the Policyholder.

Payment of Premium

We provide insurance in return for the payment of premiums. The Premiums are to be paid to Us by the Policyholder. The first Premium is due on or before the Policy Effective Date. After that premiums will be due monthly unless shown otherwise in the Schedule of Benefits. If any premium is not paid when due, the Policy will be cancelled as of the Premium Due Date; except as provided in the Policy Grace Period provision.

Waiver

Our failure to strictly enforce Our rights under this Policy at any time or under any circumstance shall not constitute a waiver of such rights by Us at any time under the same or different circumstances.

Workers' Compensation

This Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits; and does not satisfy any requirements for coverage by any Workers' Compensation Act or similar law.

SECTION XII – GENERAL EXCLUSIONS

Unless specifically covered by this Policy, We do not provide coverage for any loss or Injury resulting or caused, in whole or part, from:

1. War or any act of war or invasion; declared or undeclared.
2. Insured's full-time active duty in the armed forces; National Guard; military; naval; or air service; or organized reserve corps of any country or international organization.
3. Insured's piloting or serving as a crewmember or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
4. Insured being intoxicated while operating any vehicle, means of transportation or Conveyance. Intoxication is defined by the laws of the jurisdiction where such Accident occurs.
5. Alcoholism; drug addiction; or the use of any drug or narcotic except as prescribed by a Physician.
6. Insured's voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician.
7. Insured's Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage.
8. Disease or disorder of the body or mind.
9. Insured's violation of or attempt to violate any duly-enacted law or regulation; or commission or attempt to commit an assault; felony; or other illegal activity.
10. Injuries paid under Workers' Compensation, Employer's liability laws; or similar occupational Benefits.
11. Insured's participation in any motorized vehicular race or speed contest.
12. To the extent We are prohibited from providing coverage or making payment by any type of travel restriction; trade restriction; economic sanction; or embargo imposed by the U.S. government.
13. Insured's active participation in acts of terrorism, civil commotion or riots of any kind.

14. Insured's travel or flight in or on any aircraft or, including entering or exiting from:
    a. while riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
    b. while being used for any test or experimental purpose; or
    c. while piloting; operating; learning to operate; or serving as a member of the crew thereof; except as covered in this Policy; or
    d. while traveling in any such aircraft or device which is owned; controlled; or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Insured or any member of his or her household, except as covered in this Policy; or
    e. being flown by the Insured or which the Insured is a member of the crew; or
    f. being used for: i) crop dusting; spraying or seeding; giving and receiving flying instructions; fire fighting; sky writing; sky diving or hang gliding; pipeline or power line inspection; bungee-cord jumping; parasailing; aerial photography or exploration; racing; endurance tests; stunts or acrobatic flying; or ii) any operation that requires a special permit from the FAA, even if it is granted. (This does not apply if the permit is required solely because of the territory flown over or landed on.);
    g. designed for flight above or beyond the earth's atmosphere;
    h. which is an ultra light; or glider;
    i. being used for the purpose of skydiving; or parachuting;
    j. being used by any military authority; except an aircraft used by the Air Mobility Command or its foreign equivalent.

In addition to the exclusions above, We will not pay Accident Medical Dental and Sickness Expense Benefits for any loss, Treatment or services resulting from or contributed to by:

1. Pre-Existing Conditions.
2. Pregnancy; childbirth; or voluntary abortion.
3. Any elective Treatment; surgery; health Treatment; or examination; including any service; Treatment; or supplies that: (a) are deemed by Us to be experimental; and (b) are not recognized and generally accepted medical practices in the United States.
4. Cosmetic surgery; except for reconstructive surgery needed as the result of an Injury.
5. Eyeglasses; contact lenses; hearing aids.
6. Charges for Treatment which are not Medically Necessary.
7. Routine physicals, immunizations or other examinations where there are no objective indications or impairment in normal health, and lobotomy diagnostic or x-ray examinations.
8. Elective surgery which can be postponed until the Insured returns to his/her Home country, where the objective of the Trip is to seek medical advice, Treatment or surgery.
9. Covered Expenses incurred for which the Trip to the Host Country was undertaken to seek medical Treatment for a condition.

Pre-Trip Information – Travel Assistance – Medical Assistance

Assistance Services listed in this section are not insurance benefits. Costs and expenses associated with the services provided by CareFree Travel Assistance™ are your responsibility, unless stated otherwise.

Not a care in the world… when you have a 24/7 global network to assist you on your travels.

CareFree Travel Assistance™

- Inoculation information
- Travel information including visa/passport requirements
- Lost passport/travel documents assistance
- Embassy or Consulate Referral
- Currency exchange rates
- Worldwide public holiday information
- Lost baggage search; stolen luggage replacement assistance
- Emergency cash transfer assistance
- Emergency telephone interpretation assistance
- Urgent message relay to family, friends, or business associates
- Legal referrals/bail bond assistance
- Rental Vehicle Return
- ATM locator
- Up-to-the-minute information on local medical advisories, epidemics, required immunizations and available preventive measures
- Emergency return travel arrangements
- Claims Assistance Services

Medical & Emergency Assistance

- Physician/hospital/dental/vision referrals
- Eyeglasses and corrective lens replacement assistance
- Emergency prescription replacement
- In-patient and out-patient medical case management
    - Arrangement of doctor appointments
    - Arrangement of hospital admission
    - Medical Monitoring
    - Guarantee of medical expenses incurred during hospitalization
    - Review of Medical Expenses
    - Collection of Claims Documents

Emergency Transportation Services

The services in this section are insurance benefits. Costs and expenses for these are covered as defined in your insurance] policy. CareFree Travel Assistance™ coordinates the assistance services and facilitates payment on behalf of Aon Affinity.

- Emergency medical evacuation transportation assistance
- Repatriation of mortal remains
- Arrangement of visitors to the bedside of a hospitalized insured

CareFree Travel Assistance™ can be accessed by calling **877-303-5909** or, from outside the US or Canada, call direct: **516-342-4594**.

Note that the problems of distance, information, and communications make it impossible for Aon Affinity, the travel supplier, or CareFree Travel Assistance™ to assume any responsibility for the availability, quality, use, or results of any emergency service. In all cases, you are still responsible for obtaining, using, and paying for your own required services of all types.

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