INSURING AGREEMENT
This is Your Travel Insurance Policy, which should be read together with Your Certificate and the application form and/or declaration made by You and forms the contract of Insurance between You and Us, International Insurance Company of Hannover SE but it is only valid if You have paid the premium.

Subject to the Definitions, Conditions, Benefits Limits and Exclusions contained in this Policy, You will be eligible for the Benefits set out in this Policy whilst you are on a trip away from your Home Country during the Period of Coverage.

The Policy Benefits has been based upon the information shown in Your Certificate. Please read it carefully to make sure that the details on Your Certificate are correct.

The Policy Benefits are subject to certain Policy Conditions and Exclusions, which may not be suitable for Your requirements.

Nick Parr, Chief Executive Officer
Signed on behalf of International Insurance Company of Hannover SE.

WHO ARE WE

International Insurance Company of Hannover SE
Registered Address: 10 Fenchurch Street, London EC3M 3BE, UK
Registered No: SE00081
Authorized by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Financial Services Register No. 202640

JURISDICTION AND CHOICE OF LAW

This insurance shall be governed by and construed in accordance with the law of Washington. Each party agrees to submit to the exclusive jurisdiction of any competent court within the United States of America.

All communications between You and US shall be conducted in English except as otherwise provided in the Policy.

YOUR CANCELLATION RIGHTS

If You decide that You want to cancel this Policy, you must notify Us within 14 days of receipt of your Certificate and Policy. We will provide you with a full refund of the Premium You have paid, provided You have not started Your journey and no claim under Your Policy has occurred.

If You notify Us that you want to cancel this Policy after this period or after You have started Your journey, We will refund a percentage of the premium You have paid calculated on a daily pro-rata basis equivalent to the period of cover left unused provided that no claims have been made. If a claim has been made, or there has been an incident which may lead to a claim, We will not refund Your premium.

REASONABLE CARE

You must exercise reasonable care to prevent illness, injury or loss or theft or damage to your documents as if uninsured, and avoid wilful exposure to danger, except in an attempt to save a human life.

COMPLAINTS PROCEDURE

Our Service to You
Our goal is to give excellent service to all Our customers but We recognize that things do go wrong occasionally. We take all complaints We receive seriously and aim to resolve all of Our customers’ problems promptly. To ensure that We provide the kind of service You
expect We welcome Your feedback. We will record and analyze Your comments to make sure We continually improve the service We offer.

What is a complaint?
A Complaint is an expression of dissatisfaction not resolved to Your satisfaction within 48 hours. This does not include normal claims negotiation where offers are rejected/discussed unless You specifically state the matter is to be treated as a complaint or if negotiations have reached deadlock. A complaint does include the rejection of a claim or the settlement amount for a claim where the parties have reached deadlock in negotiations and where You believe you have been offered a poor service.

Who to tell
In the event of you having a complaint please contact Us by addressing Your complaint to Our “Complaints Department” at Our registered address, set out above. We will acknowledge your complaint promptly.

What happens next
We will write directly to you to acknowledge receipt of the complaint and explain the complaints process. We will investigate by requesting information/evidence where needed from the parties involved and will write directly to You with any updates. We will then issue You with Our final response to Your complaint.

If you remain dissatisfied with the Our final response, you may be entitled to refer the matter to the Financial Ombudsman Service (FOS). Following this complaints procedure, does not affect your right to take legal action.

Please note, the FOS will only consider a complaint if We have issued Our final response to your complaint or eight weeks have elapsed since We received the complaint.

The FOS’s contact details are:
website: www.financial-ombudsman.org.uk
email: complaint.info@financial-ombudsman.org.uk
phone: 0800 023 4567 or 0300 123 9123

Financial Services Compensation Scheme (FSCS)
The Insurer is a member of the FSCS. You may be entitled to compensation from FSCS in the event We are unable to meet Our obligations.

The FSCS’s contact details are:
Financial Services Compensation Scheme, 10th Floor, Beaufort House, 15 St Botolph Street, London, EC3A 7QU
website: www.fscs.org.uk
phone: 0800 678 1100 or 020 7741 4100
Useful Telephone Numbers and Websites
On Call International Call Centre: +1 603-328-1358
Claims Administrator: studentclaims@oncallinternational.com
Complaints: +1 855-878-9590
Financial Ombudsmen: +1 855-878-9590
Financial Services Compensation Scheme: +1 855-878-9590

Who to contact in the event of Claim
Claims for self-paid medical expenses incurred outside the United States should be submitted to: studentclaims@oncallinternational.com
Or
On Call Intl Claims Dept.,
One Delaware Drive, Salem, NH 03079
Tel: 603 328 1300 | Fax: 603 328-1770

Medical Advice
You cannot travel against the advice of Your Physician or after You have received a terminal prognosis or if You are travelling purely for the purpose of medical treatment. If You choose to do so all Our liability under this Policy shall cease.

Pre-authorization requirements for any evacuation, or any treatments, or costs, or charges or expenses.
All Medical Evacuations, Inpatient Hospital treatments or care, Surgery or Surgical Procedure, computerized tomography (CAT Scan) and Magnetic Resonance Imaging (MRI), must be pre-authorized by On Call International.

If You do not comply with this pre-authorization requirement We will be unable to pay for Your treatments or costs, charges or expenses that You incur.

To comply with the pre-authorization requirements, You or a third party must:
1. Contact On Call International at the telephone number contained in Your Certificate as soon as possible before the expense is to be incurred; and
2. Comply with the reasonable instructions of On Call International and submit any information or documents they may reasonably require; and
3. Take reasonable steps to notify Your treating Physicians, Hospitals and other providers that this Policy contains pre-authorization requirements and ask them to fully cooperate with On Call International.

If in an emergency it is not reasonably possible for You to obtain pre-authorization from On Call International for Inpatient Hospital treatments or care, Surgery or Surgical Procedure, You or a third party must notify them as soon as reasonably practicable after Your admission as an In-patient in which case all Your charges will be paid by Us subject to the terms and conditions, benefit limits, restrictions and exclusions contained in this Policy.

Right of Recovery
We will apply any money We recover from someone else under a right of subrogation in the following order:
1. Our administration and legal costs arising from the recovery.
2. Your uninsured loss (less Your excess if applicable).
3. The amount We paid You for Your claim.
Once We pay Your total loss We will keep all money left over.
If We have paid Your total loss and You receive a payment from someone else for that loss or damage, You must pay Us the amount of that payment up to the amount of the claim We paid You.
If We pay You for lost or damaged property and You later recover the property or it is replaced by a third party, You must pay Us the amount of the claim We paid You.

Right of Repatriation
In the event of You requiring any medical treatment or, Hospital or medical services, We reserve the right to arrange Your return to Your Home Country either before or after You receive medical treatment or Hospital or medical services if in the opinion of Our Medical Claims Management Company and Your treating Physician You are medically fit to travel and it is safe for You to do so. If You refuse to return when declared medically fit to do so We will not pay for any continuing medical treatment or Hospital or medical services or any recurrence or complications arising from or directly or indirectly related thereto.

Subrogation
We may, at our discretion undertake in Your name and on Your behalf, control and settlement of proceedings for our own benefit in Your name to recover compensation or secure indemnity from any party in respect of anything covered by this policy. You are to assist and permit to be done, all acts and things as required by Us for the purpose of recovering compensation or securing indemnity from other parties to which We may become entitled or subrogated, upon Us paying Your claim under this policy regardless of whether We have yet paid Your claim and whether or not the amount We pay You is less than full compensation for Your loss.
These rights exist regardless of whether Your claim is paid under a non-indemnity or an indemnity clause of this policy.

Sanction Limitation and Exclusion Clause
We shall not provide cover or pay or be liable for any claims or provide any benefit under this Policy if by providing any cover, paying any claims or providing any benefit under this Policy would expose Us to any sanction, prohibition or restriction under United Nations
resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

**Claims Procedure**
If in relation to any claim under this Policy You must contact the Claims Administrator as soon as reasonably possible after any event or occurrence which may result in a claim and in any event no later than 30 days after the occurrence of such event.

You must:

1. At Your expense, provide them with a written notification of a claim containing as much information as possible of the loss, destruction, damage, accident, injury or illness, including the amount of the claim.
2. Provide them at Your own expense with all certificates, information and evidence reasonably required by them and in the form and of such nature as they may prescribe.
3. Immediately pass to them unanswered, all communications from third parties in relation to any event that may result in a claim under this Policy.
4. Not admit or repudiate liability, nor offer to settle, compromise, make payment or pay any claim under this Policy without their written agreement.

As soon as possible after the occurrence of any Accidental Bodily Injury or Illness the Covered Person must obtain and follow the advice of a Qualified Medical Practitioner. We shall not be liable for any consequences arising due to the Covered Person’s failure to obtain and follow such advice and use such appliance or remedies as may be prescribed.

In the case of Accidental Death of the Covered Person We shall be entitled to have a post-mortem examination at Our own expense.

If You or the Covered Person fail to follow any of these conditions You will lose your right to indemnity or payment for that claim.

**Security Assistance**
In the event that you require a Political or Natural Disaster Evacuation please contact On Call International

**Telephone:** +1 603-328-1358

On Call International provides responses in respect of Political or Natural Disaster Evacuation

Assistance and support is given to You through

- In house expert crisis management and response consultants
- In house security analysts.
- A network of response teams and security professional throughout the world.
- In country assistance and deployable resources in support and response to an emergency situation.

**Medical Assistance**
On Call International will advise on and where appropriate arrange all medical treatment, medical evacuation or repatriation, travel and accommodation.

In the event of a Medical Emergency overseas please contact On Call International

**Telephone:** +1 603-328-1358

On Call International has experienced multi-lingual staff that will:

- Take charge of enquiries 24 hours a day 365 days a year and where necessary contact hospitals and guarantee any necessary fees.
- Talk to doctors and hospital staff in their own language.
- Ensure medical advisers are consulted at the outset for their views on the possibility of arranging Repatriation and the best method of transportation to be adopted.

Provided medical treatment, travel or accommodation has been arranged by On Call International. We will pay all associated costs incurred on behalf of You the Covered Person for the following:

- Making arrangements for the Covered Persons to travel home and where necessary ensure they are escorted by a medical attendant.
- Ensure assistance is provided upon arrival in the Covered Person’s Home Country following a Medical Repatriation.
- Making arrangements for the outward and return journeys for the next of kin or other nominated person to visit a sick or injured Covered Person.
- Assist in locating and sending drugs if not available locally.
- Provide advice on minor ailments.

**POLICY EXCESS AMOUNTS**

There is no policy excess
DATA PROTECTION
Please read this notice carefully as it contains important information about our use of your personal information. Your personal information means any information we hold about you and any information you give us about anyone else. You should show this notice to anyone else insured or proposed to be insured under your policy as it will also apply to them. It explains how we use all the information we have about you and the other people insured under your policy.

Please note that if you give us false or inaccurate information this could give us the right to void your policy or it could impact your ability to claim.

Sensitive information
Some of the personal information that we ask you to provide is known as “sensitive personal data”. This will include information relating to health issues, race, religion and any criminal convictions. We need to use sensitive personal data to provide you with quotes, arrange and manage your policy and to provide the services described in your policy documents (such as dealing with claims).

How we use your personal information
We will use your personal information to arrange and manage your insurance policy, including handling underwriting and claims and issuing renewal documents and information to you or your insurance adviser.
We may have to share your personal information with other insurers, statutory bodies, regulatory authorities, our business partners or agents providing services on our behalf and other authorised bodies.

We will share your personal information with others:
• if we need to do this to manage your policy with us including settling claims (if the claim relates to an incident which occurs abroad we may transfer your personal information outside the European Economic Area);
• for underwriting purposes, such as assessing your application and arranging your policy;
• for management information purposes;
• to prevent or detect crime, including fraud (see below);
• if we are required or permitted to do this by law (for example, if we receive a legitimate request from the police or another authority); and/or
• if you have given us permission.
You can ask for further information about our use of your personal information. If you require such information, please write to the Data Protection Officer at the address set out below.

Preventing and detecting crime
We may use your personal information to prevent crime. In order to prevent crime we may:
• check your personal information against our own databases;
• share it with fraud prevention agencies. Your personal information will be checked with and recorded by a fraud prevention agency. Other companies within the financial services industry may also search such fraud prevention agencies when you make an application to them for financial products (including credit, savings, insurance, stockbroking or money transmission services). If such companies suspect fraud, we will share your relevant personal information with them. The information we share may be used by those companies when making decisions about you. You can find out which fraud prevention agencies are used by us by writing to our Data Protection Officer at the address set out below; and/or
• share it with operators of registers available to the insurance industry to check information and prevent fraud. These include the Claims and Underwriting Exchange Register administered by Insurance Database Services Ltd. We may pass information relating to your insurance policy and any incident (such as an accident, theft or loss) to the operators of these registers, their agents and suppliers.

Dealing with others on your behalf
To help you manage your insurance policy, subject to answering security questions, we will deal with you or your husband, wife or partner or any other person whom we reasonably believe to be acting for you if they call us on your behalf in connection with your policy or a claim relating to your policy. For your protection only you can cancel your policy or change the contact address.

Marketing
We will not use your personal information and information about your use of our products and services to carry out research and analysis for marketing.

Further information
You are entitled to receive a copy of any of your personal information we hold. If you would like to receive a copy, or if you would like further information on, or wish to complain about, the way that we use personal information, please write to the Data Protection Officer at Bannerman Rendell Limited, 3 Minster Court, Minster Lane London EC3R 7DD giving your name, address and insurance policy number. We may charge you a small fee for this.

If we change the way that we use your personal information, we will write to you to let you know. If you do not agree to that change in use, you must let us know as soon as possible.

You have the right to complain to the Information Commissioner’s Office at any time if you object to the way we use your personal information. International Insurance Company of Hannover SE. 10 Fenchurch Street, London EC3M 3BE, UK Registered No: SE00081.

Authorized by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Financial Services Register No. 202640

The benefits provided by this Policy are not subject to the guaranteed renewability and portability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Covered Person may not purchase insurance for a period longer than the current Period of Coverage.

BENEFIT PAYMENTS All benefits will be paid directly to You unless On Call International has guaranteed Your expenses or charges and has made payment on Our behalf. In the event of Your death any benefits payable will be made to Your executors or

Please note that if you give us false or inaccurate information this could give us the right to void your policy or it could impact your ability to claim.

Sensitive information
Some of the personal information that we ask you to provide is known as “sensitive personal data”. This will include information relating to health issues, race, religion and any criminal convictions. We need to use sensitive personal data to provide you with quotes, arrange and manage your policy and to provide the services described in your policy documents (such as dealing with claims).

How we use your personal information
We will use your personal information to arrange and manage your insurance policy, including handling underwriting and claims and issuing renewal documents and information to you or your insurance adviser.
We may have to share your personal information with other insurers, statutory bodies, regulatory authorities, our business partners or agents providing services on our behalf and other authorised bodies.

We will share your personal information with others:
• if we need to do this to manage your policy with us including settling claims (if the claim relates to an incident which occurs abroad we may transfer your personal information outside the European Economic Area);
• for underwriting purposes, such as assessing your application and arranging your policy;
• for management information purposes;
• to prevent or detect crime, including fraud (see below);
• if we are required or permitted to do this by law (for example, if we receive a legitimate request from the police or another authority); and/or
• if you have given us permission.
You can ask for further information about our use of your personal information. If you require such information, please write to the Data Protection Officer at the address set out below.

Preventing and detecting crime
We may use your personal information to prevent crime. In order to prevent crime we may:
• check your personal information against our own databases;
• share it with fraud prevention agencies. Your personal information will be checked with and recorded by a fraud prevention agency. Other companies within the financial services industry may also search such fraud prevention agencies when you make an application to them for financial products (including credit, savings, insurance, stockbroking or money transmission services). If such companies suspect fraud, we will share your relevant personal information with them. The information we share may be used by those companies when making decisions about you. You can find out which fraud prevention agencies are used by us by writing to our Data Protection Officer at the address set out below; and/or
• share it with operators of registers available to the insurance industry to check information and prevent fraud. These include the Claims and Underwriting Exchange Register administered by Insurance Database Services Ltd. We may pass information relating to your insurance policy and any incident (such as an accident, theft or loss) to the operators of these registers, their agents and suppliers.

Dealing with others on your behalf
To help you manage your insurance policy, subject to answering security questions, we will deal with you or your husband, wife or partner or any other person whom we reasonably believe to be acting for you if they call us on your behalf in connection with your policy or a claim relating to your policy. For your protection only you can cancel your policy or change the contact address.

Marketing
We will not use your personal information and information about your use of our products and services to carry out research and analysis for marketing.

Further information
You are entitled to receive a copy of any of your personal information we hold. If you would like to receive a copy, or if you would like further information on, or wish to complain about, the way that we use personal information, please write to the Data Protection Officer at Bannerman Rendell Limited, 3 Minster Court, Minster Lane London EC3R 7DD giving your name, address and insurance policy number. We may charge you a small fee for this.

If we change the way that we use your personal information, we will write to you to let you know. If you do not agree to that change in use, you must let us know as soon as possible.

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BENEFIT PAYMENTS All benefits will be paid directly to You unless On Call International has guaranteed Your expenses or charges and has made payment on Our behalf. In the event of Your death any benefits payable will be made to Your executors or
administrators. In the event of You not having an executor or administrator the benefits will be paid out in accordance with the inheritance laws of Your Home Country.

CAUTION: All health plans have timely claim filing requirements. If you or your provider fails to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>SECTION</th>
<th>TITLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ELIGIBLE CLASSES</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>SCHEDULE OF BENEFITS</td>
<td>9</td>
</tr>
<tr>
<td>3</td>
<td>DESCRIPTION OF COVERAGES – Coverage A – Medical Expenses</td>
<td>11</td>
</tr>
<tr>
<td>4</td>
<td>DESCRIPTION OF COVERAGES – Coverage B – Accidental Death and</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Repatriation of Remains</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>DESCRIPTION OF COVERAGES – Coverage C – Medical Evacuation Benefit</td>
<td>15</td>
</tr>
<tr>
<td>6</td>
<td>DESCRIPTION OF COVERAGES – Coverage D – Bedside Visit Benefit</td>
<td>16</td>
</tr>
<tr>
<td>7</td>
<td>DESCRIPTION OF COVERAGES – Coverage E – Repatriation of Remains</td>
<td>17</td>
</tr>
<tr>
<td>8</td>
<td>GENERAL POLICY EXCLUSIONS</td>
<td>18</td>
</tr>
<tr>
<td>9</td>
<td>DEFINITIONS</td>
<td>19</td>
</tr>
<tr>
<td>10</td>
<td>EXTENSION OF BENEFITS</td>
<td>23</td>
</tr>
<tr>
<td>11</td>
<td>COORDINATION OF THIS CONTRACT’S BENEFITS WITH OTHER BENEFITS</td>
<td>24</td>
</tr>
<tr>
<td>12</td>
<td>ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE</td>
<td>28</td>
</tr>
<tr>
<td>13</td>
<td>COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN</td>
<td>30</td>
</tr>
<tr>
<td>14</td>
<td>CLAIM PROVISIONS</td>
<td>31</td>
</tr>
<tr>
<td>15</td>
<td>GENERAL PROVISIONS</td>
<td>32</td>
</tr>
</tbody>
</table>
SECTION 1
ELIGIBLE CLASSES

The Classes eligible for coverages available under the Policy are shown below. The coverages applicable to a Participating Organization or Institution are as shown in the Schedule of Benefits in the copy of the sample Certificate provided to that Participating Organization or Institution.

Class I: Students participating in travel outside of the United States for reason of study, research, internship, community engagement or experiential learning which is sponsored by University of Washington, for a length of time not to exceed one year.
SECTION 2
SCHEDULE OF BENEFITS

All benefits and limits are stated per Covered Person.

**Choice of Hospital and Physician:** Nothing contained in this Plan restricts or interferes with the Eligible Participant’s right to select the Hospital or Physician of the Eligible Participant’s choice. Also, nothing in this Plan restricts the Eligible Participant’s right to receive, at his/her expense, any treatment not covered in this Plan.

<table>
<thead>
<tr>
<th>MEDICAL BENEFITS</th>
<th>Limits are per Covered Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period of Coverage Maximum Benefits</td>
<td>$500,000</td>
</tr>
<tr>
<td>Maximum Benefit per Injury or Sickness</td>
<td>$500,000</td>
</tr>
<tr>
<td>Physician Office Visits</td>
<td>Reasonable Expenses</td>
</tr>
<tr>
<td>Hospital and Other Services</td>
<td>Reasonable Expenses</td>
</tr>
<tr>
<td>Emergency Room and Outpatient Surgical Facilities</td>
<td>Reasonable Expenses</td>
</tr>
<tr>
<td>Benefits listed below are subject to the Period of Coverage Maximum and the Maximums per Injury and Sickness. Please see the Certificate of Coverage, Section 3, for detailed descriptions of the benefits listed below.</td>
<td>Reasonable Expenses</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Reasonable Expenses</td>
</tr>
<tr>
<td>Mental, Emotional or Functional Nervous Disorders</td>
<td>Benefits are payable at the same rate as for Physical Illness, subject to the limitations stated in the Schedule of Benefits: Mental illness shall be limited to those disorders identified in the most recent edition of the International Classification of Diseases of the Diagnostic and Statistical Manual of the American Psychiatric Association.</td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td>Coverage for Medically Necessary treatment and supporting services for a Covered Person in an approved chemical dependency treatment program. The benefit is limited to $15,500. These limits do not apply to Medically Necessary detoxification provided in a Hospital unless the Covered person is currently enrolled in a chemical dependency treatment program.</td>
</tr>
<tr>
<td>Treatment of specified therapies, including acupuncture and Physiotherapy</td>
<td>Reasonable Expenses up to $10,000 Maximum combined total for Inpatient and Outpatient care, up to 30 days immediately following the attending Physician’s release for rehabilitation following a covered Hospital confinement or surgery per Period of Coverage</td>
</tr>
<tr>
<td>Therapeutic termination of pregnancy</td>
<td>Reasonable Expenses up to $500 maximum per Period of Coverage</td>
</tr>
<tr>
<td>Elective termination of pregnancy</td>
<td>Reasonable Expenses up to $300 maximum per Period of Coverage</td>
</tr>
<tr>
<td>Routine nursery care of a newborn child of a covered pregnancy</td>
<td>Reasonable Expenses up to $500 maximum per Period of Coverage</td>
</tr>
<tr>
<td>Annual cervical cytology screening</td>
<td>Reasonable Expenses</td>
</tr>
<tr>
<td>Mammography screening when screening for occult breast cancer is recommended by a Physician</td>
<td>Reasonable Expenses</td>
</tr>
<tr>
<td>Prostate screening tests</td>
<td>Reasonable Expenses</td>
</tr>
<tr>
<td>Dental Anesthesia</td>
<td>Reasonable Expenses</td>
</tr>
<tr>
<td>Breast Reconstruction due to Mastectomy</td>
<td>Reasonable Expenses</td>
</tr>
<tr>
<td>Low Protein Modified Food Products</td>
<td>Reasonable Expenses</td>
</tr>
<tr>
<td>Dental Care for an Accidental Injury</td>
<td>Reasonable Expenses up to $2,500 maximum per Period of Coverage maximum</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Outpatient prescription drugs including oral contraceptives</td>
<td>Reasonable Expenses</td>
</tr>
<tr>
<td>Diabetic Supplies/Education</td>
<td>Reasonable Expenses</td>
</tr>
<tr>
<td><strong>Other Coverages</strong></td>
<td><strong>Limits are per Covered Person</strong></td>
</tr>
<tr>
<td>Accidental Death &amp; Dismemberment</td>
<td>Maximum Benefit: Principal Sum-</td>
</tr>
<tr>
<td></td>
<td>Eligible Participant: up to $10,000</td>
</tr>
<tr>
<td></td>
<td>Partner: up to $5,000</td>
</tr>
<tr>
<td></td>
<td>Child: up to $1,000</td>
</tr>
<tr>
<td><strong>INTERNATIONAL ASSISTANCE BENEFITS</strong></td>
<td><strong>Limits are per Covered Person</strong></td>
</tr>
<tr>
<td>Medical Evacuation</td>
<td>Unlimited Maximum Lifetime Benefit for all Evacuations</td>
</tr>
<tr>
<td>Bedside Visit</td>
<td>Up to a maximum benefit of $20,000 for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one (1) person</td>
</tr>
<tr>
<td>Repatriation of Remains</td>
<td>Maximum Benefit up to $50,000</td>
</tr>
<tr>
<td>Political and Natural Disaster Evacuation</td>
<td>Maximum Benefit up to $100,000</td>
</tr>
<tr>
<td>Food and Lodging in Safe Haven and Return to Home or Alternate Study Location following PND evacuation</td>
<td>Maximum Benefit up to $5,000 includes food/lodging up to $150 per day for a maximum of three days</td>
</tr>
<tr>
<td>24 Hour Medical, Travel and Security Assistance</td>
<td>Unlimited access to assistance services including pre-trip advice, medical referrals, medical monitoring, location of lost luggage or travel documentation, legal consultation and referral and interpreter assistance</td>
</tr>
</tbody>
</table>
SECTION 3
DESCRIPTION OF COVERAGES
COVERAGE A – MEDICAL EXPENSES

A. What the Insurer Pays for Covered Medical Expenses: If a Covered Person incurs expenses while insured under the Policy due to an Injury or a Sickness, the Insurer will pay the Reasonable Expenses for the Covered Services listed below. All Covered Medical Expenses incurred as a result of the same or related cause, including any Complications, shall be considered as resulting from one Sickness or Injury. The amount payable for any one Injury or Sickness will not exceed the Maximum Benefit of $500,000 per injury or sickness for the Eligible Participant or the Maximum Benefit of $500,000 per injury or sickness for an Eligible Dependent. Benefits are subject Maximum Benefits stated in the Schedule of Benefits, specified benefits and limitations set forth under Covered Medical Expenses, the General Policy Exclusions and to all other limitations and provisions of the Policy.

B. Covered General Medical Expenses and Limitations: Covered Services are limited to the Covered Medical Expenses incurred for services, treatments and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

No Medical Treatment Benefit is payable for Covered Services incurred after the Covered Person’s insurance terminates as stated in the Period of Coverage provision. However, if the Covered Person is in a Hospital on the date the insurance terminates, the Insurer will continue to pay the Medical Treatment Benefits until the earlier of the date the Confinement ends or 31 days after the date the insurance terminates.

If the Covered Person was insured under a group policy administered by the Administrator immediately prior to the Coverage Start Date shown on the Identification Card issued to the Participant, the Insurer will pay the Medical Treatment Benefits for a Covered Injury or a Covered Sickness such that there is no interruption in the Covered Person’s insurance.

1. Physician office visits

2. Hospital and Other Services: Hospital and Other Services consist of the following: Hospital room and board, including general nursing services; medical and surgical treatment; medical services and supplies; Outpatient nursing services provided by an RN, LPN or LVN; local, professional ground ambulance services to and from a local Hospital for Emergency Hospitalization and Emergency Medical Care; X-rays; laboratory tests; prescription medicines; artificial limbs or prosthetic appliances, including those which are functionally necessary; the rental or purchase, at the Insurer’s option, of durable medical equipment for therapeutic use, including repairs and necessary maintenance of purchased equipment not provided for under a manufacturer's warranty or purchase agreement.

   The Insurer will not pay for Hospital room and board charges in excess of the prevailing semi-private room rate unless the requirements of Medically Necessary treatment dictate accommodations other than a semi-private room.

3. Emergency Room and Outpatient Surgical Facility Services: Emergency Hospital Services are Emergency Medical Care delivered in a Hospital’s emergency room or an Outpatient Treatment Facility that provides surgical procedures as defined in this Policy.

C. Additional Covered General Medical Expenses and Limitations: These additional Covered Services are limited to the Covered Medical Expenses incurred for services, treatments and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

1. Pregnancy: The Insurer will pay the reasonable expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these. Pregnancy coverage provides for prenatal screening and diagnosis of congenital disorders on the same basis as coverage for other Medically Necessary treatment of pregnancy and maternity care under this Certificate.

   Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:
   a. a minimum of 48 hours of inpatient care following a vaginal delivery; or
   b. a minimum of 96 hours of inpatient care following delivery by cesarean section.

   If the physician, in consultation with the mother, determines that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's
home, or, in a provider's office, as determined by the physician in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

a. Parental education;
b. Assistance and training in breast or bottle feeding; and
c. Performance of any Medically Necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

2. **Services for Mental, Emotional or Functional Nervous Disorders**: Benefits are payable at the same rate as for Physical Illness, subject to the limitations stated in the Schedule of Benefits: Mental illness shall be limited to those disorders identified in the most recent edition of the International Classification of Diseases of the Diagnostic and Statistical Manual of the American Psychiatric Association.

In order to qualify for inpatient benefits, services for Mental, Emotional or Functional Nervous Disorders must meet the following conditions of service:

a. Services must be for the treatment of a Mental, Emotional or Functional Nervous Disorder that can be improved by standard medical practice. Covered expenses are subject to all the provisions of the group policy that would apply to any other illness.

b. The Covered Person must be under the direct care and treatment of a Physician for the condition being treated.
   i. The Physician must certify that such Covered Person is suffering from Mental, Emotional or Functional Nervous Disorders.

C. Services must be those, which are regularly provided and billed by a Hospital.

d. Services are provided only for the number of days required to treat the Covered Person's condition.

e. Services must be received in a Hospital, Day Care Center or Non-hospital residential facility.

The term "Physician" as used in this section means a psychologist, advanced practice registered nurse or social worker, who upon certification that the individual is suffering from Mental, Emotional or Functional Nervous Disorders include subsequent referral to other treatment providers.

For the purposes of this provision, "mental health services" means medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American Psychiatric Association, on July 24, 2005, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (a) Substance related disorders; (b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American Psychiatric Association; (c) skilled nursing facility services, home health care, residential treatment, and custodial care; and (d) court ordered treatment unless the insurer's medical director or designee determines the treatment to be medically necessary.

(i) Mental health services. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services; and

(ii) Prescription drugs intended to treat any of the disorders covered, as defined in mental disorders services above, to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

3. **Chemical Dependency**: Coverage for Medically Necessary treatment and supporting services for a Covered Person in an approved chemical dependency treatment program. The benefit is limited to $15,500.

These limits do not apply to Medically Necessary detoxification provided in a Hospital unless the Covered person is currently enrolled in a chemical dependency treatment program.

The Covered Person is required to provide an initial assessment of the need for chemical dependency treatment and a treatment plan prior to scheduled treatment at his own expense between 10 and 30 working days before treatment is to begin:

a. If the Covered Person is ordered by a court of competent jurisdiction to undergo a chemical dependency assessment or treatment;

b. In a situation where the need for such treatment is related to deferral of prosecution, deferral of sentencing or suspended sentencing; or

c. In a situations pertaining to motor vehicle driving rights.

For the initial assessment the Covered Person may choose any individual that is (1) certified as a
chemical dependency professional; and (2) employed by an approved treatment program.

4. **Treatment of Specified Therapies:** Coverage for treatment received by the Covered Person who is under the care of a licensed Physician for treatment of the specified therapies stated in the Schedule of Benefits - such treatment is subject to the limitations stated in the Schedule of Benefits. Specified Therapies includes: Occupational Therapy, Physical Therapy, Vision Therapy, Hearing Therapy, Speech Therapy and Acupuncture.

5. **Therapeutic or Elective Termination of Pregnancy:** The Insurer will pay as stated in the Schedule of Benefits for a therapeutic or elective termination of pregnancy subject to the limitations stated in the Schedule of Benefits.

6. **Annual cervical cytology screening for cervical cancer and its precursor states for women:** The cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear and laboratory and diagnostic services in connection with examining and evaluating the Pap smear.

7. **Mammography screening, when screening for occult breast cancer is recommended by a Physician:** Coverage is as follows:
   a. female Covered Persons are allowed one baseline mammogram;
   b. female Covered Persons are allowed a screening mammogram annually.

8. **Prostate screening tests:** Coverage shall be provided for Prostate Specific Antigen tests and the Office Visit associated with this test when ordered by the Covered Person’s Physician or nurse practitioner.

9. **Dental anesthesia:** Coverage will be provided for general anesthesia services and related facility charges in conjunction with any dental procedure that is medically necessary for a child under age 7, is physically or developmentally disabled, or with a dental condition that cannot be safely and effectively treated in a dental office; or the person has a medical condition that the person's physician determines would place the person at undue risk if the dental procedure were performed in a dental office and the procedure is approved by the person's physician.

10. **Breast Reconstruction due to Mastectomy:** If breast reconstruction is provided in connection with a covered mastectomy, benefits will also be provided for Covered Expenses for the following:
    a. Reconstruction of the breast on which the mastectomy has been performed;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
    c. Prostheses; and
    d. Treatment for physical complications of all stages of mastectomy, including lymphedemas.

11. **Low Protein Modified Food Products:** Coverage is provided for formulas and medical foods necessary for the medically necessary treatment of a Covered Person inflicted with phenylketonuria (PKU).

12. **Dental Care for an Accidental Injury:** The insurer will pay for repairs to sound natural teeth due to an accidental injury subject to the limitations stated in the Schedule of Benefits.

13. **Outpatient Prescription Drugs:** Coverage for outpatient prescription drugs including oral contraceptives prescribed by a Physician subject to the limitations stated in the Schedule of Benefits.

16. **Diabetic Supplies/Education:** Coverage shall be provided for appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits; and outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by health care providers with expertise in diabetes.
SECTION 4
DESCRIPTION OF COVERAGE
COVERAGE B – ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Insurer will pay the benefit stated below if a Covered Person sustains an Injury in the Country of Assignment resulting in any of the losses stated below within 365 days after the date the Injury is sustained:

<table>
<thead>
<tr>
<th>Loss</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of life</td>
<td>100% of the Principal Sum</td>
</tr>
<tr>
<td>Loss of one hand</td>
<td>50% of the Principal Sum</td>
</tr>
<tr>
<td>Loss of one foot</td>
<td>50% of the Principal Sum</td>
</tr>
<tr>
<td>Loss of sight in one eye</td>
<td>50% of the Principal Sum</td>
</tr>
</tbody>
</table>

Loss of one hand or loss of one foot means the actual severance through or above the wrist or ankle joints. Loss of the sight of one eye means the entire and irrecoverable loss of sight in that eye.

If more than one of the losses stated above is due to the same Accident, the Insurer will pay 100% of the Principal Sum. In no event will the Insurer pay more than the Principal Sum for loss to the Covered Person due to any one Accident.

The Principal Sum is stated in the Schedule of Benefits.

There is no coverage for loss of life or dismemberment for or arising from an Accident in the Covered Person’s Home Country.
If an Covered Person is involved in an accident or suffers a sudden, unforeseen illness requiring emergency medical services, while traveling outside of his/her home country and adequate medical facilities are not available, the Administrator will coordinate and pay for a medically-supervised evacuation, up to the Maximum Limit shown in the Schedule of Benefits, to the nearest appropriate medical facility. This medically-supervised evacuation will be to the nearest medical facility only if the facility is capable of providing adequate care. The evacuation will only be performed if adequate care is not available locally and the Injury or Sickness requires immediate emergency medical treatment, without which there would be a significant risk of death or serious impairment. The determination of whether a medical condition constitutes an emergency and whether area facilities are capable of providing adequate medical care shall be made by physicians designated by the Administrator after consultation with the attending physician on the Covered Person’s medical conditions. The decision of these designated physicians shall be conclusive in determining the need for medical evacuation services. Transportation shall not be considered medically necessary if the physician designated by the Administrator determines that the Covered Person can continue his/her trip or can use the original transportation arrangements that he/she purchased.

The Insurer will pay Reasonable Charges for escort services if the Covered Person is a minor or if the Covered Person is disabled during a trip and an escort is recommended in writing by the attending Physician and approved by the Insurer.

As part of a medical evacuation, the Administrator shall also make all necessary arrangements for ground transportation to and from the hospital, as well as pre-admission arrangements, where possible, at the receiving hospital.

If following stabilization, when medically necessary and subject to the Administrator’s prior approval, the Insurer will pay for a medically supervised return to the Covered Person’s permanent residence or, if appropriate, to a health care facility nearer to their permanent residence or for one-way economy airfare to the Covered Person’s point of origin, if necessary.

All evacuations must be approved and coordinated by Administrator designated physicians. Transportation must be by the most direct and economical route.

With respect to this provision only, the following is in lieu of the Policy’s Extension of Benefits provision: No benefits are payable for Covered Expenses incurred after the date the Covered Person’s insurance under the Policy terminates. However, if on the date of termination the Covered Person is Hospital Confined, then coverage under this benefit provision continues until the earlier of the date the Hospital Confinement ends or the end of the 31st day after the date of termination.

The combined benefit for all necessary evacuation services is listed in the Schedule of Benefits.
SECTION 6
DESCRIPTION OF COVERAGES
COVERAGE D – BEDSIDE VISIT BENEFIT

If a Covered Person is Hospital Confined due to an Injury or Sickness for more than 7 days while traveling outside of his/her home country the Insurer will pay up to $20,000 for the cost of one economy round-trip air fare ticket to and hotel accommodations in, the place of the Hospital Confinement for one person designated by the Covered Person. Payment for meals, ground transportation and other incidentals are the responsibility of the family member or friend.

With respect to any one trip, this benefit is payable only once for that trip, regardless of the number of Covered Persons on that trip. The determination of whether the Covered Member will be hospitalized for more than 7 or is in critical condition shall be made by the Administrator after consultation with the attending physician. No more than one (1) visit may be made during any Period of Coverage. No benefits are payable unless the trip is approved in advance by the Plan Administrator.
SECTION 7
DESCRIPTION OF COVERAGE E
– REPATRIATION OF REMAINS

If a Covered Person dies while traveling or living outside of his/her home country during the Period of Coverage, the Insurer will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Schedule of Benefits, for the preparation of the body for burial, or the cremation, and for the transportation of the remains to his/her Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body, urns, caskets, coffins, visitation, burial or funeral expenses. Any expense for repatriation of remains requires approval in advance by the Plan Administrator.

No benefit is payable if the death occurs after the Termination Date of the Plan. However, if the Covered Person is Hospital Confined on the Termination Date, eligibility for this benefit continues until the earlier of the date the Covered Person’s Confinement ends or 31 days after the Termination Date. The Insurer will not pay any claims under this provision unless the expense has been approved by the Plan Administrator before the body is prepared for transportation.
SECTION 8
GENERAL POLICY EXCLUSIONS

Unless specifically provided for elsewhere under the Policy, the Policy does not cover loss caused by or resulting from, nor is any premium charged for, any of the following:

1. No benefits will be paid under this plan for expenses incurred inside the United States.
2. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health, unless otherwise noted.
3. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury, unless otherwise noted.
4. Surgery for the correction of refractive error and services and prescriptions for eye examinations, eye glasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury.
5. Plastic or cosmetic surgery, unless they result directly from an Injury which necessitated medical treatment within 24 hours of the Accident.
6. For diagnostic investigation or medical treatment for infertility or fertility.
7. Expenses incurred in excess of Reasonable Expenses.
8. Organ or tissue transplant.
9. Expenses incurred from participating in an illegal occupation or committing or attempting to commit a felony.
10. While traveling against the advice of a Physician, while on a waiting list for a specific treatment, or when traveling for the purpose of obtaining medical treatment.
11. The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Policy.
12. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction’s of teeth, or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia.
13. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
14. Diagnosis and treatment of acne and sebaceous cyst.
15. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.
16. Loss due to war, declared or undeclared; service in the armed forces of any country or international authority; participation in a riot or civil commotion.
17. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.
18. Loss arising from participation in professional sports, scuba diving, hang gliding, parachuting, or bungee jumping.
19. Medical Treatment Benefits provision for loss due to or arising from a motor vehicle Accident if the Covered Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.
20. Under the Medical Expense and the Accidental Death and Dismemberment provisions, for injury and illness related medical costs and for loss of life or dismemberment for or arising from an Accident in the Covered Person’s Home Country.
21. Expenses incurred prior to the beginning of the current Period of Coverage or after the end of the current Period of Coverage except as described in Covered General Medical Expenses and Limitations and Extension of Benefits.
22. Expenses incurred without pre-authorisation as defined with Policy Conditions.
SECTION 9
DEFINITIONS

Unless specifically defined elsewhere, wherever used in the Policy, the following terms have the meanings given below.

**Accident (Accidental)** means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Covered Person is insured under the Policy.

**Age** means the Covered Person’s attained age.

**Ambulatory Surgical Facility** means an establishment which may or may not be part of a Hospital and which meets the following requirements:
1. Is in compliance with the licensing or other legal requirements in the jurisdiction where it is located;
2. Is primarily engaged in performing surgery on its premises;
3. Has a licensed medical staff, including Physicians and registered nurses;
4. Has permanent operating room(s), recovery room(s) and equipment for Emergency Medical Care; and
5. Has an agreement with a Hospital for immediate acceptance of patients who require Hospital care following treatment in the ambulatory surgical facility.

**Chemical Dependency** means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user’s health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

**Certificate of Coverage** is the document issued to each Eligible Participant outlining the benefits under the Plan.

**Complications** means a secondary condition, an Injury or a Sickness, that develops or is in conjunction with an already existing Injury or Sickness.

**Confinement (Confined)** means the continuous period a Covered Person spends as an Inpatient in a Hospital due to the same or related cause.

**Congenital Condition** means a condition that existed at or has existed from birth, including, but not limited to, congenital diseases or anomalies that cause functional defects.

**Country of Assignment** means the country for which the Eligible Participant has a valid visa, if required, and in which he/she is undertaking an educational activity.

**Covered Medical Expenses** are the expenses incurred for Covered Services. Covered Medical Expenses for Covered Services received providers will not exceed Reasonable Expenses. In addition, Covered Medical Expenses may be limited by other specific maximums described in this Plan. An expense is incurred on the date the Covered Person receives the service or supply.

**Covered Services** are an expense actually incurred by or on behalf of a Covered Person for those services and supplies which are:
1. administered or ordered by a Physician;
2. Medically Necessary to the diagnosis and treatment of an Injury or Sickness;
3. are not excluded by any provision of the Policy; and incurred while the Covered Person’s insurance is in force under the Policy, except as stated in the Extension of Benefits provision. A Covered Medical Expense is deemed to be incurred on the date such service or supply which gave rise to the expense or charge was rendered or obtained.

**Covered Person** means an Eligible Participant and any Eligible Dependents as described in the appropriate eligibility section, for whom premium is paid and who is covered under the Policy.

**Durable Medical Equipment** means medical equipment which:
1. Is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
2. Can withstand long term repeated use without replacement;
3. Is not useful in the absence of Injury or Sickness; and
4. Can be used in the home without medical supervision.
The Insurer will cover charges for the purchase of such equipment when the purchase price is expected to be less costly than rental.

Eligible Dependent: An Eligible Dependent may be the Eligible Participant’s partner and/or his/her unmarried dependent children under age 25. The attainment of age 25 shall not operate to terminate the coverage of such child while the child is and continues to be both (1) incapable of self-sustaining employment by reason of developmental disability or physical handicap and (2) chiefly dependent upon the Eligible Participant for support and maintenance, provided proof of such incapacity and dependency is furnished to the Insurer by the Eligible Participant within 31 days of the child’s attainment of age 25 and subsequently as may be required by the Insurer. This insurance will continue for as long as the Covered Person’s insurance stays in force and the child remains incapacitated. The term “child/children” includes a natural child, a legally adopted child, a stepchild, and a child who is dependent on the Eligible Participant during any waiting period prior to finalization of the child’s adoption.

This term includes an Eligible Dependent:
1. With a similar visa or passport, accompanies the Eligible Participant while that person is engaged in international educational activities; and
2. Is temporarily located outside the Eligible Participant’s Home Country as a non-resident alien.

As used above:
1. The term “partner” means an Eligible Participant’s lawful spouse or domestic partner.
2. The term “domestic partner” means a person of the same or opposite sex who:
   a. Is not married or legally separated;
   b. Is not currently registered as domestic partner with a different domestic partner;
   c. Occupies the same residence as the Eligible Participant;
   d. Has not entered into a domestic partnership relationship with an Eligible Participant that is temporary, social, political, commercial or economic in nature; and
   e. Has entered into a domestic partnership arrangement with the Eligible Participant.
3. The term “domestic partnership arrangement” means the Eligible Participant and another person of the same or opposite sex occupies the same residence as the Eligible Participant, and shares a Joint lease, mortgage or deed and household expenses.

Eligible Participant means a person who:
1. Is a student engaged in study abroad travel sponsored by the participating organization
2. Is temporarily located outside the United States for a period not to exceed 365 days; and
3. Has not obtained permanent residency status.

Emergency Hospitalization and Emergency Medical Care means hospitalization or medical care to screen and stabilize a Covered Person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. This includes care that is provided for an Injury or a Sickness condition manifesting itself by acute symptoms of sufficient severity including without limitation sudden and unexpected severe pain for which the absence of immediate medical attention could reasonably result in:
1. Permanently placing the Covered Person’s health in jeopardy, or
2. Causing other serious medical consequences; or
3. Causing serious impairment to bodily functions; or
4. Causing serious and permanent dysfunction of any bodily organ or part.

Medically necessary detoxification will be considered Emergency Medical Care. Previously diagnosed chronic conditions in which subacute symptoms have existed over a period of time shall not be included in this definition of a medical emergency, unless symptoms suddenly become so severe that immediate medical aid is required.

Group means a preparatory or high school; an institution of higher learning offering a course of general studies leading to a bachelor's degree, master's degree or doctorate; a part of a university offering a specialized group of courses; or an institution offering instruction in a professional, vocational, or technical field.

Home Country means the Covered Person’s country of domicile named on the enrollment form or the roster received from the Participating Organization or Institution, as applicable. However, the Home Country of an Eligible Dependent who is a child is the same as that of the Eligible Participant.
Hospital means a facility that:
1. Is primarily engaged in providing by, or under the supervision of doctors of medicine or osteopathy, Inpatient services for the diagnosis, treatment, and care, or rehabilitation of persons who are sick, injured, or disabled;
2. Is not primarily engaged in providing skilled nursing care and related services for persons who require medical or nursing care;
3. Provides 24 hours nursing service; and
4. Is licensed or approved as meeting the standards for licensing by the applicable local licensing authority.

Immediate Family means the spouse, children, brothers, sisters or parents of a Covered Person.

Injury means bodily injury caused directly by an Accident. It must be independent of all other causes. To be covered, the Injury must first be treated while the Covered Person is insured under the Policy. A Sickness is not an Injury. A bacterial infection that occurs through an Accidental wound or from a medical or surgical treatment of a Sickness is an Injury.

Inpatient means a person confined in a Hospital for at least 18 hours and charged room and board.

Intensive Care Facility means an intensive care unit, cardiac care unit or other unit or area of a Hospital:
1. Which is reserved for the critically ill requiring close observation; and
2. Which is equipped to provide specialized care by trained and qualified personnel and special equipment and supplies on a standby basis.

Low Protein Food products shall mean a food product that is especially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low protein food products shall not include a natural food that is naturally low in protein.

Medically Necessary services or supplies are those that the Insurer determines to be all of the following:
1. Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition.
2. Provided for the diagnosis or direct care and treatment of the medical condition.
3. Within standards of good medical practice within the organized community.
4. Not primarily for the patient's, the Physician’s, or another provider’s convenience.
5. The most appropriate supply or level of service that can safely be provided. For Hospital stays, this means acute care as an inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person’s condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Policy.

Mental Illness means any psychiatric disease identified in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual.

Non-hospital Residential Facility means a facility accredited in the local jurisdiction where it is located as a qualified non-hospital provider of treatment for chemical dependency, mental illness, or any combination of these, in any residential setting.

Other Plan means any of the following which provides benefits or services for, or on account of, medical care or treatment:
1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage, and medical benefits coverage in group, group-type and individual automobile “no fault” and “traditional fault” type contracts. It does not include student accident-type coverage.
2. Coverage under a governmental plan or 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). It also does not include any plan when, by law, its benefits are excess of those of any private program or other non-governmental program.

Outpatient means a person who receives medical services and treatment on an Outpatient basis in a Hospital, Physician’s office, Ambulatory Surgical Facility, or similar centers, and who is not charged room and board for such services.

Outpatient treatment facility means a clinic, counseling center, or other similar location that is accredited in the local jurisdiction where it is located as a qualified provider of outpatient services for the treatment of chemical dependency, or
mental illness.

**Outpatient Surgical Center** means a public or private establishment, either free standing or as part of a Hospital, with an organized staff of Physician’s and with permanent facilities equipped to mainly do surgery. It does not provide services or other accommodations for patients to stay overnight; but has the services of a Physician and Registered Nurse at all times when a patient is present. This term does not include a Physician’s office.

**Participating Organization or Institution** means University of Washington which has elected that its Eligible Participants and, if applicable, the dependents of those Eligible Participants be covered under the Policy and which has been accepted by the Insurer for coverage under the Policy.

**Physician** means a currently licensed practitioner of the healing arts acting within the scope of his/her license. It does not include the Covered Person or his/her spouse, parents, parents-in-law or dependents or any other person related to the Covered Person or who lives with the Covered Person.

**Physiotherapy** means a physical or mechanical therapy, diathermy, ultrasonic, heat treatment in any form, manipulation or massage.

**Period of Coverage** means the period beginning on the Covered Person’s effective date. It ends on the earlier of:
1. The date the Covered Person’s insurance under the Policy ends; or
2. The last day of the current School Year Semester as defined by the Participating Organization or Institution; or
3. The date the Covered Person returns to his or her Home Country.

**Reasonable Expense** means the normal charge of the provider, incurred by the Covered Person, in the absence of insurance,
1. for a medical service or supply, but not more than the prevailing charge in the area for a like service by a provider with similar training or experience, or
2. for a supply which is identical or substantially equivalent

**Registered Nurse** means a graduate nurse who has been registered or licensed to practice by a Board of Nurse Examiners or other authority, and who is legally entitled to place the letters “R.N.” or “R. P.N.” after his/her name.

**School Year** means the period of time commencing either: (i) on the first day of the fall Quarter and ending on the last day of the spring Quarter as defined by the Organization or Institution; or (ii) the date determined by the Organization or Institution.

**Semester** means either of the two usually 18-week periods of instruction into which an academic year is often divided or a period of six months.

**Sickness** means an illness, ailment, disease, or physical condition of a Covered Person starting while insured under the Policy.

**Total Disability or Totally Disabled**
1. With respect to a Covered Person who otherwise would be employed, Total Disability or Totally Disabled means the Covered Person’s complete inability to perform all the substantial and material duties of his/her regular occupation while under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability.
2. With respect to a Covered Person who would not otherwise be employed, Total Disability or Totally Disabled means the Covered Person’s inability to engage in the normal activities of a person of like age and sex while:
   a. Under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability, or
   b. Hospital Confinement or home confined at the direction of his/her Physician due to Injury or Sickness, except for trips away from home to receive medical treatment.

**You, Your, Member or Covered Person** shall mean Covered Person.

**We, Us, Our, The Company or The Insurer** means the International Insurance Company of Hannover SE

**Written Request** means a request on any form provided by the Administrator for particular information.

11:59:59 p.m. means 11:59:59 p.m. at the Covered Person’s location.
12:00:01 a.m. means 12:00:01 a.m. at the Covered Person’s location.
SECTION 10
EXTENSION OF BENEFITS
If the Insurer terminates the Policy, coverage will be extended for a Covered Person who is Totally Disabled on the date coverage ends.

Coverage under this provision is provided only for Covered Medical Expenses with respect to a Totally Disabled Covered Person, for the condition causing the Total Disability.

Coverage so extended will end on the first of the following to occur:
1. The 90th day following termination of the Policy; or
2. The date the Total Disability ends; or
3. The end of the current Period of Coverage.

Except as stated above, coverage is not provided for any expense incurred after the date the Policy terminates.

This coverage extension will not apply to termination initiated by any Covered Person, Participating Organization or Institution or the Policyholder.
SECTION 11
COORDINATION OF THIS CONTRACT’S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits according to its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.
   1. Plan includes: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
   2. Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan. Notwithstanding any other stipulations found herein, this plan will act as Primary plan for all claims incurred outside the United States.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan’s benefits. When This plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the Total Allowable expense for that claim. This means that when this Plan is Secondary, it must pay the amount which, when combined with what the Primary plan paid, totals 100% of the highest Allowable expense. In addition, if this Plan is Secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary plan) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an Allowable expense under this Plan. If this Plan is Secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

D. Allowable expense is a health care expense, which is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:
1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

E. Closed panel plan is a Plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows: A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. (1) Except as provided in subsection (2), a Plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both Plans state that the complying plan is primary.
   (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

   a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      • The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
      • If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

   b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;
ii. If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

iii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above determine the order of benefits;

iv. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection (a) above determine the order of benefits; or

v. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

• The Plan covering the Custodial parent, first;
• The Plan covering the spouse of the Custodial parent, second;
• The Plan covering the non-custodial parent, third; and then
• The Plan covering the spouse of the non-custodial parent, last

c. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subsection (a) or (b) above determine the order of benefits as if those individuals were the parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D (1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D (1) can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

6. If the preceding rules do not determine the order of benefits, the Allowable expenses must be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total Allowable expense for that claim Total Allowable expense is the highest Allowable expense of the Primary plan or the Secondary plan. In addition, the Secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. The Insurer or its designated representative may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. The Insurer or its designated representative need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give the Insurer or its designated representative any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

If payments that should have been made under This plan are made by another Plan, the issuer has the right, at its discretion, to remit to the other Plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered benefits paid under This plan. To the extent of such payments, the issuer is fully discharged from liability under This plan.

RIGHT OF RECOVERY

The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

For Questions about Coordination of Benefits: Contact Your State Insurance Department
SECTION 12
ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE

Eligible Participant: Eligible Participant means any person who satisfies the definition of an Eligible Participant and the requirement of an applicable class as shown in Section 1 – Eligible Classes. He/she must not be insured under the Policy as a dependent. When both spouses are insured as Eligible Participants under the Policy, only one spouse shall be considered to have any Eligible Dependents.

Enrollment for Coverage: An Eligible Participant must enroll for coverage by completing an enrollment form and paying any required premium prior to the date he or she arrives in the Country of Assignment. If dependent coverage is offered by the Policyholder, an Eligible Participant may also enroll his/her Eligible Dependents for coverage on the later of:
1. The effective date of his/her insurance; or
2. Within 31 days from the date on which the Dependent arrives in the Country of Assignment.

When an Eligible Participant’s Coverage Starts: Coverage for an Eligible Participant starts at 12:00:01 a.m. on the latest of the following:
1. The effective date shown on the Insurance Identification Card, if any;
2. The date the requirements in Section 1 - Eligible Classes are met; or
3. The date the premium and completed enrollment form, if any, are received by the Insurer or the Administrator.

Thereafter, the insurance is effective 24 hours a day, outside of the United States. In no event, however, will insurance start prior to the date the premium is received by the Insurer.

When an Eligible Participant’s Coverage Ends: Coverage for an Eligible Participant will automatically terminate on the earliest of the following dates:
1. The date the Policy terminates;
2. The Participating Organization’s or Institution’s Termination Date;
3. The date of which the Eligible Participant ceases to meet the Individual Eligibility Requirements;
4. The date the Eligible Person returns to the United States;
5. The date the Eligible Participant requests cancellation of coverage (the request must be in writing); or
6. The premium due date for which the required premium has not been paid, subject to the Grace Period provision.
7. The end of any Period of Coverage.

Any unearned premium will be returned upon request, but returned premium will only be for the number of full months of the unexpired term of coverage. Premium will be refunded in full or pro-rated if it is later determined that the Covered Person is not eligible for coverage or if the enrollment form contained inaccurate or misleading information.

Coverage will end at 11:59:59 p.m. on the last date of insurance. A Covered Person’s coverage will end without prejudice to any claim existing at the time of termination.

When an Eligible Dependent’s Coverage Starts: An Eligible Dependent may only be added or dropped from coverage in the case of a qualifying event defined as marriage, death, loss of coverage, divorce, entry into or departure from the Country of Assignment. An Eligible Dependent’s coverage starts at 12:00:01 a.m. on the latest of the following:
1. The effective date of the Eligible Participant’s insurance;
2. The effective date shown on the insurance identification card, if any;
3. The date the eligibility requirements in this section are met; or
4. The date the completed enrollment form, if any, and premium are received by the Insurer.

Thereafter, the insurance is effective 24 hours a day, outside the United States. In no event, however, will insurance start prior to the date the enrollment form, if any, with premium is received by the Insurer or one of its authorized agents.

When an Eligible Dependent’s Coverage Ends: An Eligible Dependent’s coverage automatically ends on the earliest of the following dates:
1. The date the Policy terminates; or
2. The Participating Organization’s or Institution’s Termination Date;
3. The date the Eligible Participant is no longer covered under the Policy;
4. The date the member returns to the United States;
5. The date the Covered Person requests cancellation of coverage (the request must be in writing);
6. The premium due date for which the required premium has not been paid, or
7. The date on which the dependent ceases to meet the eligibility requirements.
8. The end of any Period of Coverage.

Coverage will end at 11:59:59 p.m. on the last date of insurance. A dependent's coverage will end without prejudice to any claim.
SECTION 13
COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN

Coverage of Newborn Infants: A newborn child of the Eligible Participant will automatically be a Covered Person for 60 days from the moment of his/her birth if the birth occurs while the Policy is in force, and subject to the particular coverages and amounts of insurance as specified for Eligible Dependents in the Schedule of Benefits. “Expenses for Routine nursery care” of a newborn infant of a covered Pregnancy are covered up to the limits, if any, shown in the Schedule of Benefits. Notice is only required for continued coverage beyond 60 days if additional premium is required.

Coverage of Adopted Children: An adopted child of the Eligible Participant is covered on the same basis as described above for a newborn. Coverage starts on the date of placement with the Eligible Participant for adoption, provided the Eligible Participant’s coverage is then in force. Coverage terminates if the placement is disrupted and the child is removed from placement. Notice is only required for continued coverage beyond 60 days if additional premium is required.

Newborn children are covered for the Medically Necessary treatment of medically diagnosed congenital defects, birth abnormalities and premature birth.

Expenses for routine nursery care means the charges of a Hospital and attending Physician for the care of a healthy newborn infant while Confined. Care includes treatment of standard neo-natal jaundice.

In order to continue the coverage of a newborn child beyond the 60th day following his/her date of birth or of an adopted child beyond the 60th day following his/her placement:
1. Written notice of the birth or of placement of the child must be provided to the Insurer or to the Administrator within 60 days from the date of birth or placement; and
2. The required payment of the appropriate premium, if any, must be received by the Insurer.

If 1. and 2. above are not satisfied, coverage of a newborn child or of the adopted child will terminate 60 days from the date of birth or placement.
SECTION 14
CLAIM PROVISIONS

Notice of Claim: Written notice of any event which may lead to a claim under the Policy must be given to the Insurer or to the Administrator within 30 days after the event, or as soon thereafter as is reasonably possible.

Claim Forms: Upon receipt of a written notice of claim, the Insurer will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If these forms are not furnished within 15 days after the notice is sent, the claimant may comply with the Proof of Loss requirements of the Policy by submitting, within the time fixed in the Policy for filing proofs of loss, written proof showing the occurrence, nature and extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the Insurer or to its Administrator within 90 days after the date of loss. However, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, this proof may be furnished within 90 days after termination of each period for which the Insurer is liable. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give proof within 90 days, provided
1. it was not reasonably possible to provide proof in that time; and
2. the proof is given within one year from the date proof of loss was otherwise required. This one year limit will not apply in the absence of legal capacity

Time for Payment of Claim: Benefits payable under the Policy will be paid immediately upon receipt of satisfactory written proof of loss, unless the Policy provides for periodic payment. Where the Policy provides for periodic payments, the benefits will accrue and be paid monthly, subject to satisfactory written proof of loss.

Payment of Claims: Benefits for accidental loss of life under Coverage B will be payable in accordance with the beneficiary designation and the provisions of the Policy which are effective at the time of payment. If no beneficiary designation is then effective, the benefits will be payable to the estate of the Covered Person for whom claim is made. Any other accrued benefits unpaid at the Covered Person’s death may, at the Insurer’s option, be paid either to his/her beneficiary or to his/her estate. Benefits payable under Coverages A, C, D, and E shall be payable to the provider of the service. Benefits payable under Coverage B, other than for loss of life, will be paid to the Covered Person.

If any benefits are payable to the estate of a Covered Person, or to a Covered Person’s beneficiary who is a minor or otherwise not competent to give valid release, the Insurer may pay up to $1,000 to any relative, by blood or by marriage, of the Covered Person or beneficiary who is deemed by the Insurer to be equitably entitled to payment. Any payment made by the Insurer in good faith pursuant to this provision will fully discharge the Insurer of any obligation to the extent of the payment.

Physical Examination and Autopsy: The Insurer may, at its expense, examine a Covered Person, when and as often as may reasonably be required during the pendency of a claim under the Policy and, in the event of death, make an autopsy in case of death, where it is not forbidden by law.
SECTION 15
GENERAL PROVISIONS

Entire Contract: The entire contract between the Insurer and the Policyholder consists of the Policy, this Certificate, the application of the Policyholder and the application of the Participating Organization or Institution, copies of which are attached to and made a part of the Policy. All statements contained in the applications will be deemed representations and not warranties. No statement made by an applicant for insurance will be used to void the insurance or reduce the benefits, unless contained in a written application and signed by the applicant. No insurance producer has the authority to make or modify the Policy, or to extend the time for payment of premiums, or to waive any of the Insurer’s rights or requirements. No modifications of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by one of the Insurer’s officers and delivered to the Policyholder.

Incontestability: The validity of a Covered Person’s insurance will not be contested except for nonpayment of premium or false statements made on their enrollment form. No statement made by a Covered Person relating to his/her insurability will be used in defense of a claim under the Policy unless: 1. it is contained in the enrollment form signed by the Covered Person; and 2. a copy of the enrollment form has been furnished to the Covered Person, or to his/her beneficiary.

Time Limit on Certain Defenses: No claim for loss incurred after the effective date of the Covered Person’s insurance will be reduced or denied on the grounds that the disease or physical condition existed prior to the effective date of the Covered Person’s insurance. This provision does not apply to a disease or physical condition excluded by name or specific description.

Legal Actions: No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of 3 years after the written proof of loss is required to be furnished.

Conformity with State Statutes: Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which it is delivered is hereby amended to conform to the minimum requirements of those statutes.

Assignment: No assignment of benefits will be binding on the Insurer until a copy of the assignment has been received by the Insurer or by its Administrator. The Insurer assumes no responsibility for the validity of the assignment. Any payment made in good faith will relieve the Insurer of its liability under the Policy.

Beneficiary: The beneficiary is the last person named in writing by the Covered Person and recorded by or on the Insurer’s behalf. The beneficiary can be changed at any time by sending a written notice to the Insurer or to its Administrator. The beneficiary’s consent is not required for this or any other change in the Policy unless the designation of the beneficiary is irrevocable.

Mistake in Age: If the age of any Covered Person has been misstated, an equitable adjustment will be made in the premiums or, at the Insurer’s discretion, the amount of insurance payable. Any premium adjustment will be based on the premium that would have been charged for the same coverage on a Covered Person of the same age and similar circumstances.

Clerical Error: A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

Not in Lieu of Workers’ compensation. The Policy does not satisfy any requirement for Workers’ Compensation.

Subrogation: If the Covered Person suffers an Injury or Sickness through the act or omission of another person, and if benefits are paid under the Policy due to that Injury or Sickness, then to the extent the Covered Person recovers for the same Injury or Sickness from a third party, its insurer, or the Covered Person’s uninsured motorist insurance, the Insurer will be entitled to a refund of all benefits the Insurer has paid from such recovery. Further, the Insurer has the right to offset subsequent benefits payable to the Covered Person under the Policy against such recovery. However, these subrogation rights will only be enforced if the injured party has been fully compensated for his/her injuries. The Insurer will only seek recovery to the extent of actual benefits paid by us on an injured parties’ claim.

The Insurer may file a lien in a Covered Person’s action against the third party and have a lien upon any recovery that the Covered Person receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. The Insurer shall have a right to recovery of the full amount of benefits paid under the Policy for the Injury or Sickness. The Insurer will not be responsible for the Covered Person’s attorneys’ fees or other cost.
Upon request, the Covered Person must complete the required forms and return them to the Insurer or to the Administrator. The Covered Person must cooperate fully with the Insurer in asserting his/her right to recover. The Covered Person will be personally liable for reimbursement to the Insurer to the extent of any recovery obtained by the Covered Person from any third party. If it is necessary for the Insurer to institute legal action against the Covered Person for failure to repay the Insurer, the Covered Person will be personally liable for all costs of collection, including reasonable attorneys’ fees.

**Right of Recovery:** Whenever the Insurer have made payments with respect to benefits payable under the Policy in excess of the amount necessary, the Insurer shall have the right to recover such payments. The Insurer shall notify the Covered Person of such overpayment and request reimbursement from the Covered Person. However, should the Covered Person not provide such reimbursement, the Insurer has the right to offset such overpayment against any other benefits payable to the Covered Person under the Policy to the extent of the overpayment.

**Currency:** All premiums for and claims payable pursuant to the Policy are payable only in the currency of the United States of America.

**Grievance Procedures:** If the Covered Person’s claim is denied in whole or in part, he/she will receive written notification of the denial. The notification will explain the reason for the denial.

The Covered Person has the right to appeal any denial of a claim for benefits by submitting a written request for reconsideration with the Insurer. Requests for reconsideration must be filed within 60 days after receipt of the written notification of denial. When the Insurer receives the Covered Person’s written request, the Insurer will review the claim and arrive at a determination.

If the matter is still not resolved to the Covered Person’s satisfaction, he/she may request a second review of the claim by sending the Insurer a written request for a second reconsideration. This written request must be filed within 60 days of the Eligible Participant’s receipt of the Insurer’s written notification of the result of the first review. If the issue involves a dispute over the coverage of medical services, or the extent of that coverage, the second review will be completed by physician consultants who did not take part in the initial reconsideration.

The Insurer shall not take any retaliatory action, such as canceling coverage against the Group because any person acting on the Group’s behalf has filed a complaint against the Insurer or has appealed a decision made by the Insurer.

**Dispute Resolution**

All complaints or disputes relating to coverage under this Plan must be resolved in accordance with the Insurer’s grievance procedures as defined on Page 2 of this Insurance Policy. Grievances may be reported by telephone or in writing. If requested to do so, we will assist you in putting the complaint in writing. All grievances received by the Insurer that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Covered Person and the Insurer will be acknowledged in writing, along with a description of how the Insurer propose to resolve the grievance.

The Insurer shall not take any retaliatory action, such as canceling coverage, against the Insured Participant and his/her Insured Dependents or the Group because the Insured Participant’s, the Group’s, or any person’s action on the Covered Person’s or the Group’s behalf, has filed a complaint against the Insurer or has appealed a decision made by the Insurer.
The Contract of Insurance
This is Your Political and Natural Disaster Evacuation Insurance Policy, which with the application form and/or declaration made by You and Certificate should be read together and forms the contract of Insurance between You and Us, International Insurance Company of Hannover SE but it is only valid if You have paid the premium.

Your premium has been based upon the information shown in Certificate and recorded in the written application You have signed and/or declaration You have made. Please read them carefully to make sure that they meet Your requirements and that the details on Certificate are correct. If after reading Your Policy and Certificate You have any questions, please contact Your insurance adviser.

In return for You having paid the premium for the Period of Coverage, We will indemnify You by payment in respect of the Evacuation Costs of the Covered Persons to the extent of and subject to the terms contained in or endorsed on the Policy.

IMPORTANT
This Policy is a legal contract. You must tell Us about any facts or changes which affect Your insurance and which have occurred either since the Policy started or since the last renewal date.

If You are not sure whether certain facts are relevant please ask Your adviser. If You do not tell Us about relevant changes, Your Policy may not be valid or the Policy may not cover You fully.

You should keep a written record (including copies of letters) of any information You give Us or Your insurance adviser when You renew this Policy.

Choice of Law
The laws of England and Wales apply and in any suit or legal action the courts of England and Wales shall have jurisdiction unless We agree with You otherwise.

Data Protection
It is understood by the Covered Person that any information about him will be processed by Us in compliance with the Data Protection Act 1998 and only for the purpose of providing Insurance cover and handling any claims. This may necessitate providing such information to third parties although the protection provided by the Act shall still apply.

International Insurance Company of Hannover SE
Registered Address: 10 Fenchurch Street, London EC3M 3BE, UK
Registered No: SE00081
Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Financial Services Register No. 202640
Our Service to You
Our goal is to give excellent service to all Our customers but We recognise that things do go wrong occasionally. We take all complaints We receive seriously and aim to resolve all of Our customers' problems promptly. To ensure that We provide the kind of service You expect, We welcome Your feedback. We will record and analyse Your comments to make sure We continually improve the service We offer.

What will happen if You complain
1. We will acknowledge your complaint within 2 working days of receipt.
2. We aim to resolve complaints, following assessment and investigation, within 5 working days of receipt.

Most of Our customers' concerns can be resolved quickly but occasionally more detailed enquiries are needed. If this is likely, We will contact You with an update and give You an expected date of response.

What to do if You are dissatisfied
Seek resolution by your insurance adviser or with Us.

If You are disappointed with any aspect of the handling of Your insurance We would encourage You, in the first instance, to contact the manager concerned. You can write or telephone, whichever suits You, and ask your contact to review the problem.

If You remain unhappy with the decision You receive from Us, You may write to the Complaints Officer.

If You are dissatisfied with Our final decision from the Complaints Officer, You may be entitled to refer the matter to the Financial Ombudsman Service (FOS).

Full contact details of both Our Managing Director and the FOS will be provided at the same time as We acknowledge Your complaint.

Note that the FOS will only consider Your complaint if You have given Us the opportunity to resolve it and You are a private Policyholder, a business with a group turnover of less than $1 million, a charity with an annual income of less than $1 million, or a Trustee of a trust with a net asset value of less than $1 million. If, however, We do not resolve Your complaint within 40 working days, the FOS will accept a direct referral.

Whilst We are bound by the decision of the FOS, You are not. Following the complaint procedure does not affect Your right to take legal action.

Financial Services Compensation Scheme
Our obligations are covered by the Financial Services Compensation Scheme (FSCS). If We were unable to meet Our obligations, You could be entitled to compensation from this scheme, depending on the type of insurance and the circumstances at the time.

You would be covered for all of the first $2,000 of any claim and 90% of the remainder without any upper limit.

Further information about compensation scheme arrangements is available from the FSCS website www.fscs.org.uk, or write to Financial Services Compensation Scheme, 7th floor Lloyds Chambers, Portsoken Street, London E1 8BN.
Useful Telephone Numbers and Websites
On Call International Call Centre: +1 603-328-1358
Claims Administrator: studentclaims@oncallinternational.com
Complaints: +1 855-878-9590
Financial Ombudsmen: +1 855-878-9590
Financial Services Compensation Scheme: +1 855-878-9590

Security Assistance
In the event that you require a Political or natural Disaster Evacuation please contact On Call International

Telephone: +1 603-328-1358

On Call International provides responses in respect of Political or Natural Disaster Evacuation.

Assistance and support is given to You through
- In house expert crisis management and response consultants
- In house security analysts.
- A network of response teams and security professional throughout the world.
- In country assistance and deployable resources in support and response to an emergency situation.
Definitions
Each time We use one of the words or phrases listed below, it will have the same meaning wherever it appears in Your Policy unless We state otherwise. A defined word or phrase will start with a capital letter each time it appears in the Policy, except for headings and titles.

Annual Aggregate Limit
The maximum We will pay in respect of all claims payable during the Period of Insurance.

Appropriate Authorities
The Foreign and commonwealth Office of the United Kingdom, The United States Department of State, the Foreign Office of Canada or similar authority of the Policyholder’s Host Country.

Assignment
When an Covered Personis working in or travelling to a country on Your behalf.

Country of Domicile
The country in which the Covered Personresided in before taking up Assignment and/or the country to which the Covered Personshall return to when repatriated or country in which they hold a valid passport.

Evacuation Costs
The costs incurred within 30 days of an Insured Event to evacuate the Covered Person to the nearest place of safety or their Country of Domicile.

If the Covered person is in imminent peril, cover will apply to the evacuation of the Covered Person by any appropriate means consistent under the circumstances with their health and safety, otherwise cover hereunder will apply to the transportation only at economy fares unless unavailable or manifestly impractical.

Expenses
The cost of accommodation, transportation and food and any other reasonable and necessary expenses.

Hibernation Costs
The costs of security and relocation if an Insured Event has occurred and at the sole discretion of the On Call International the Covered Person may remain in their Host Country, in either their current location or relocate to a site chosen by the On Call International up to a period of 14 days from the time the Insured Event first occurs.

Host Country
The country in which the Covered Person resides in whilst on Assignment.

Insured Event
1. The Insured’s Appropriate Authority issues a travel advice for a particular country or region where the Covered Person is on Assignment in, recommending that certain categories of person which includes the Covered Person should leave that country or region.
   - or -
2. The recognised Government in their Host Country:
   a) Declares a state of emergency necessitating immediate evacuation or
   b) Formally recommends or instructs that the Covered Person should leave that country or region for safety or
   c) Seizes, confiscates or expropriates the Insured or Covered Person’s property, plant or equipment or
   d) Expels the Covered Person or declares the Covered Person “persona non grata”.
   e) Withdraws all scheduled international commercial flights for a period of excess of 24 hours as a result of political or military action intervention which has a direct impact on the Covered persons safety and prevents them leaving the country.
3. Natural Disaster within their Host Country which has a direct impact on the Covered Person and their safety.
4. The Political or military events in the country the Covered Person is staying in represents an imminent threat to their safety.

Insured Journey
Whilst the Covered Person is on a journey not exceeding 12 months in duration (unless otherwise agreed by Us) which You have authorised in connection with The Business (including any period of holiday which is purely ancillary to the Insured Journey) which begins during the Period of Insurance, and commences from the time the Covered Person leaves their home or place of business in their Country of Domicile whichever is the later and continues during the entire period of the journey and terminating at the time of return to their home or place of business in their Country of Domicile whichever is reached first.
Covered Person
As shown in The Policy Schedule.

Operative Time of Cover
The period of time for which We will cover the Covered Person for benefits described within the The Policy Schedule.

Period of Insurance
From the effective date until the expiry date shown in The Policy Schedule and any subsequent period for which We accept payment for renewal of this Policy.

The Business
Activities directly connected with The Business described in The Policy Schedule.

The Policy Schedule

We/Us/Our/The Company
International Insurance Company of Hannover SE.

You/Your/The Policyholder
The Covered Person or persons, companies, partnerships or unincorporated associations named in The Policy Schedule as The Policyholder.
Conditions
The following Conditions apply to this Policy.

Adjustable Premium
If it has been agreed with Us that any part of the premium, being based on estimates, is adjustable You shall within 30 days of the end of each Period of Insurance provide Us with the actual figures and the premium will be adjusted accordingly.

Aggregate Limit
If the aggregate amount of all benefits payable exceeds the stated Aggregate Limit the benefits payable to an Covered Person shall be proportionately reduced until the total of all Benefits does not exceed the Aggregate Limit.

Alteration of Risk
We will at Our option void the Policy from the inception of this insurance where there has been any alteration to The Business and/or the occupation or pursuits of any Covered Person after the effective date of this insurance which increases the risk of loss, liability, destruction, damage, accident, injury or illness or where Your interest ceases except by will or operation of law unless We have accepted the alteration.

Assignment
You may not assign the benefits under this Policy. We shall not be bound to accept or be affected by any notice of any trust charge, lien, purported assignment or other dealing with or relating to this Policy.

Cancellation
We may cancel this Policy by sending You 30 days written notice to Your last known address and We will return any unearned proportion of the premium paid.

You may cancel this Policy at any time prior to departure or by sending us 14 days written notice and any unearned premium shall be returned to you provided that We have not made any claims payment under this policy or have any claims for consideration or You are not aware of any claims that have not been reported to Us. Any claim payments made or under consideration shall be deducted from the amount of unearned premium due to be returned.

Contribution
If at the time of an event giving rise to a claim there is any other insurance Policy in force in Your name which covers You or the Covered Person for the same expense, loss or liability We will only pay a proportion of the claim being determined by reference to the cover provided by each of the relevant policies.

Force Majeure
We shall not be liable for failure to provide Services and/or delays caused by acts of God, strikes or other conditions beyond our reasonable control, including but not limited to flight conditions or situations where the performance of this Policy is prohibited or delayed by local laws, regulations or regulatory agencies. We shall notify You immediately of any Force Majeure event.

In the event of such Force Majeure lasting longer than 7 days You will have the right to cancel this Policy immediately and We shall return any premium paid by You less any amount for claims paid or due to be paid.

Fraud
If a claim made by You or anyone acting on Your behalf, or any person claiming to be indemnified is fraudulent or exaggerated, whether ultimately material or not or if a false declaration or statement is made or if a fraudulent device is used in support of a claim We may at Our option void the Policy from the inception of this insurance or cancel the Policy from the date of the claim or alleged claim and repudiate the claim.

Identification
The Policy and The Policy Schedule will read as one contract. A particular word or phrase which is not defined will have its ordinary meaning.

Reasonable Precautions
You must take all reasonable precautions to avoid accident, injury or illness to any person, or loss, destruction or damage to their property, and You must comply with all legal requirements and safety regulations and conduct The Business in a lawful manner. If in relation to any claim You have failed to fulfil any of these conditions, You will lose your right to indemnity or payment for that claim.

The Contracts (Rights of Third Parties) Act 1999
The Contracts (Rights of Third Parties) Act 1999 or any amendment thereto does not apply to this Policy. Only We and the Policyholder can enforce the terms of this Policy. No other party may benefit from this contract as of right. The Policy may be varied or cancelled without the consent of any third party.

**Misdescription**

We will void this Policy if there has been any misrepresentation, misdescription or failure to disclose any material fact by You or anyone acting for You.

**Rate Variations**

We may give you 14 days notice of any change to rates charged to cover War under this policy.

**Sanction Limitation and Exclusion Clause**

We shall not provide cover or pay or be liable for any claims or provide any benefit under this Policy if by providing any cover, paying any claims or providing any benefit under this Policy would expose Us to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

**Claims Conditions**

The following Claims Conditions apply to this Policy.

1. Our On Call International must be advised immediately of any situation that may give rise to a claim or as soon as reasonably possible thereafter. If the Crisis Management Call Centre is not contacted immediately Our liability to pay any subsequent claim under this section will cease.
2. You must provide Us and On Call International with all assistance and information requested in a timely manner.
3. The Covered Person must follow the advice of On Call International at all times.
4. Where you or an Covered Person is entitled to any refund on unused tickets or returnable deposits or advanced payments We will be entitled to deduct these from the value of any claim.
5. You and the Covered Person shall take all reasonable and necessary steps to ensure that the existence of this Cover is not made common knowledge.
6. You must not make or attempt to make arrangements without the agreement of Our On Call International.

**Exceptions**

The following Exceptions apply to this Policy.

This Policy does not cover

1. Any expense related to the Covered Person engaging in the commission of, or the attempt to commit, an unlawful act.
2. Any expense incurred as a result of the Covered Person engaging in active service in the armed forces or police of any nation; active participation in war (whether declared or not), invasion, act of foreign enemy, hostilities, civil war, rebellion, riot, revolution or insurrection unless declared to Us and accepted by Us in writing.
3. Any losses incurred by You which are or would be, except for this insurance recoverable under any other insurance or other indemnity available to You.
4. Any losses incurred for which You are responsible under a Workmen’s Compensation Act.
5. The Covered Person being in their own Country of Domicile or country in which they hold a valid passport.
6. Your failure to reasonably prove that there is any threat to the Covered Person’s safety.
7. You taking part in any political activity or operations of any security or armed forces unless declared to and agreed by Us.
8. Or attributable to an alleged violation of the laws of the Host Country by You or the Covered Person.
9. Your failure to maintain and possess duly authorised and issued required immigration, work, residence or similar visas or permits or other relevant documentation required in the Covered Person’s Host Country.
10. Accommodation, Evacuation Expenses or Hibernation Costs incurred more than 30 days after the Insured Event.
11. Or attributable in whole or in part to a debt insolvency, commercial failure, the repossession of any property by any title holder or lien holder, or any other financial cause.
12. Your failure to honour any contractual obligation bond or specific performance condition in a license.
13. You at inception of this Policy having prior knowledge of or had received information of any specific matter, fact or circumstance which would lead to an Insured Event that has not been declared to and accepted by Us.
14. Any Losses incurred by You that have been increased by Your failure to follow the advice of Our On Call International.
15. Any losses that have been increased by Your failure to follow the advice of On Call International promptly.
Cover

We will indemnify You up to the sums insured shown in The Policy Schedule if during the Operative Time of Cover You incur Evacuation Costs, Hibernation Costs and Expenses as a result of an Insured Event in Your Host Country.

In the event that you require a Political or natural Disaster Evacuation please contact On Call International

Telephone:  +1 603-328-1358