United States Fire Insurance Company
Administrative Office: 5 Christopher Way,
Eatontown, NJ 07724
(Hereinafter referred to as "the Company")

TRAVEL PROTECTION INSURANCE
Certificate of Insurance

This Certificate of Insurance describes all of the travel insurance benefits underwritten by United States Fire Insurance Company, herein referred to as the Company. The insurance benefits vary from program to program. Please refer to the accompanying Schedule of Benefits. It provides the Insured with specific information about the program he or she purchased. The Insured should contact the Company immediately if he or she believes that the Schedule of Benefits is incorrect.

Signed for the Company,

Marc J. Adee
Chairman and CEO

Insurance provided by this Certificate is subject to all of the terms and conditions of the Group Policy. If there is a conflict between the Policy and Certificate, the Policy will govern.

If the Insured is not completely satisfied with the insurance he or she must notify the Company within 15 days of purchase and return the certificate. The Company will give the Insured a full refund of premium provided he or she has not already departed on the Covered Trip or filed a claim.

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Travel Delay (Up to $250 Per Day) $1,500
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Missed Connection……..……..$1,500
Change Fee……..…….$250
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Part B – Travel Insurance Benefits

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Optional Coverage

Applicable only when specifically requested on the application and the appropriate additional premium has been paid and purchase confirmed on Your Schedule of Benefits.

Cancel For Any Reason Benefit.....Up To 75% of Non-Refundable Trip Cost
Interruption For Any Reason Benefit.....Up To 75% of Non-Refundable Trip Cost

SECTION I. COVERAGES

COVERAGE A
24-HOUR ACCIDENTAL DEATH AND DISMEMBERMENT

This Coverage A Benefit is provided only if shown as covered on the Schedule of Benefits.

You are eligible for benefits 24 hours a day, up to the Maximum Benefit Amount shown when you sustain an Injury during the Covered Trip which results in a Loss noted below within 180 days of the date of the Injury causing the Loss.

Benefits will be paid as follows:

Type of Loss	Benefit Amount
Loss of life	Principle Sum
Loss of both feet	Principle Sum
Loss of both hands	Principle Sum
Loss of both eyes	Principle Sum
Loss of one hand and one foot	Principle Sum
Loss of one hand and one eye	Principle Sum
Loss of one foot and one eye	Principle Sum
Loss of one hand	Half of the Principle Sum
Loss of one foot	Half of the Principle Sum
Loss of one eye	Half of the Principle Sum

Loss of hand or hands, or foot or feet, means severance at or above the wrist joint or ankle joint, respectively,

Loss of eye or eyes means the total and irrecoverable loss of the entire sight thereof. Only one of the amounts shown above (the largest applicable) will be paid for Injuries resulting from one accident.

The benefit for loss of: (a) two limbs; (b) both eyes; or (c) one limb and one eye is payable only when such loss results from the same accident.

The Principal Sum is shown in the Schedule of Benefits.

EXPOSURE AND DISAPPEARANCE

If, while insured under this Coverage A, You are unavoidably exposed to the elements because of a covered accident and suffer a loss for which benefits are payable under this Coverage A, such loss will be covered.

If, while insured under this Coverage A, You are in an accident resulting in the disappearance, sinking or damaging of an air or water conveyance on which You are covered by this Coverage A, and if Your body has not been found within 52 weeks from the date of the accident, it will be presumed, unless there is evidence to the contrary, that he or she suffered loss of life as a result of those Injuries.

COVERAGE B
ACCIDENT MEDICAL EXPENSE

For the purpose of this benefit:

"Covered Expense" means expense incurred for services and supplies: (a) listed below; and (b) ordered or prescribed by a Legally Qualified Physician as Medically Necessary for diagnosis or treatment; which is limited to:

1. The services of a Legally Qualified Physician;
2. Hospital or ambulatory medical-surgical center services (this will also include expenses for a cruise ship cabin or hotel room, not already included in the cost of the Insured's Covered Trip, if recommended as a substitute for a hospital room for recovery of an Injury);
3. transportation furnished by a professional ambulance company to and/or from a Hospital; and prescribed drugs, prosthetics and therapeutic services and supplies.

Benefits will be paid for the expense incurred, up to the Maximum Benefit Amount, if an Insured incurs a Covered Expense as a result of an accidental Injury, which occurs during the Covered Trip. You must receive the initial Medical Treatment for the Injury within 30 days after the date of the accident, which caused the Injury. All services, supplies or treatment must be received within the 52 weeks following the date of the accident.

Benefits will include expenses for emergency dental treatment due to accidental Injury not to exceed $500.00.

Benefits will not be paid in excess of the Usual and Customary Charges.

Advance payment will be made to a Hospital, up to the Maximum Benefit Amount, if needed to secure an Insured's admission to a Hospital, because of a covered accidental Injury. The authorized travel assistance company will coordinate advance payment to the Hospital.

These benefits will not duplicate any benefits payable under the policy or any coverage(s) attached to the policy.

The maximum Benefit Amount is shown in the Schedule of Benefits.

COVERAGE C
SICKNESS MEDICAL EXPENSE

This Coverage C is made a part of the policy. It is subject to all the provisions of this Coverage C.

For the purposes of this benefit:

"Covered Expense" means expense incurred for services and supplies: (a) listed below; and (b) ordered or prescribed by a Legally Qualified Physician as Medically Necessary for diagnosis or treatment; which is limited to:

1. The services of a Legally Qualified Physician;
2. Hospital or ambulatory medical-surgical center services (this will also include expenses for a cruise ship cabin or hotel room, not already included in the cost of the Insured's Covered Trip, if recommended as a substitute for a hospital room for recovery of a Sickness);
3. Transportation furnished by a professional ambulance company to and/or from a Hospital; and
4. Prescribed drugs, prosthetics and therapeutic services and supplies.

Benefits will be paid for the expense incurred, up to the Maximum Benefit Amount, if You incur a Covered Expense as a result of Sickness, which manifests itself during the Covered Trip. You must receive initial Medical Treatment for the Sickness within 30 days of onset of the Sickness. All services, supplies or treatment must be received within the 52 weeks following the onset of the Sickness.

Benefits will include expenses for emergency dental treatment not to exceed $500.00.

Benefits will not be paid in excess of the Usual and Customary Charges.

Advance payment will be made to a Hospital, up to the Maximum Benefit Amount, if needed to secure an Insured's admission to a Hospital, up to the Maximum Benefit Amount, because of a covered Sickness. The authorized travel assistance company will coordinate advance payment to the Hospital.

These benefits will not duplicate any benefits payable under the policy or any coverage(s) attached to the policy.

The maximum Benefit Amount is shown in the Schedule of Benefits.

COVERAGE D
TRIP CANCELLATION

This Coverage D is made a part of the policy. It is subject to all the provisions of this Coverage D.

Benefits will be paid up to the Maximum Benefit Amount purchased to cover You for the Published Penalties and unused non-refundable prepaid expenses for Travel Arrangements when You are prevented from taking his or her Covered Trip due to:

1. Death involving You or Your Traveling Companion or You or Your Traveling Companions Business Partner or Your Family Member;

2. A covered Sickness or Injury involving You, Your Traveling Companion or Business Partner, or Your Family Member or Your Traveling Companion which necessitates Medical Treatment at the time of

cancellation and results in medically imposed restrictions, as certified by a Legally Qualified Physician, which prevents an Insured's participation in the Covered Trip;

3. Your or Your Traveling Companion being hijacked, quarantined, required to serve on a jury (notice of jury duty must be received after the Effective Date) served with a court order to appear as a witness in a legal action in which You or Your Traveling Companion is not a party (except law enforcement officers);

4. You or Your Traveling Companion's principal place of residence being rendered uninhabitable by unforeseen circumstances or fire or flood or burglary of primary residence within 30 days of departure;

5. You or Your or Traveling Companion being directly involved in a traffic accident, which must be substantiated by a police report, while en route to an Insured's scheduled point of departure;

6. Bankruptcy or Default of an airline, or cruise line, tour operator or travel supplier (other than the tour operator or travel agency from whom You purchased your travel arrangements) which stops service more than 14 days following Your Effective Date. Benefits will be paid due to Bankruptcy or Default of an airline only if no alternate transportation is available. If alternate transportation is available, benefits will be limited to the change fee charged to allow the Insured to transfer to another airline in order to get to the Insured's intended destination. This benefit only applies if the policy has been purchased within 21 days of the Insured's initial payment for the Covered Trip and for the full cost of the Covered Trip.

7. Unannounced strike that causes complete cessation of services of Your Common Carrier for at least 12 consecutive hours;

8. Weather that causes complete cessation of services of Your Common Carrier for at least 12 consecutive hours;

9. Natural disaster at the site of the Insured's destination, which renders their destination accommodations uninhabitable

10. Felonious Assault on You or on Your Traveling Companion within 10 days of the scheduled Departure Date;

11. You or Your Traveling Companion is in the Military and called to emergency duty for a national disaster other than war;

12. Employer termination or layoff affecting You or a person(s) sharing the same room with You during Your Covered Trip. Employment must have been with the same employer for at least 1 continuous year;

13. A Terrorist Incident that occurs in a city listed on the itinerary of Your Covered Trip and within 30 days prior to Your Scheduled Departure Date. Benefits are not provided if the Travel Supplier offers a substitute itinerary.;

14. Revocation of Your previously granted leave or re-assignment due to war. Official written revocation/re-assignment by a supervisor or commanding officer of the appropriate branch of service will be required.;

15. Your family or friends living abroad with whom You were planning to stay are unable to provide accommodations due to life threatening illness, life threatening injury or death of one of them.

16. Your or Your Traveling Companion's place of employment is rendered unsuitable for business due to fire, flood, burglary or other Natural Disaster and You and/or Your Traveling Companion are required to work as a result.;

17. a documented theft of passports or visas;

18. a permanent transfer of employment of 250 miles or more.;

19. You, Your Traveling Companion or a Family Member traveling with You is required to work during the Trip. A written statement by an unrelated company official and/or the human resources department demonstrating revocation of previously approved time off will be required.

20. You, Your Traveling Companion or Family Member traveling with You are directly involved in the merger of Your employer or the acquisition of Your employer by another company;

21. a cancellation of the Insured's Trip if the Insured's arrival on the Trip is delayed and causes the Insured to lose 50% or more of the scheduled Trip duration due to the reasons covered under the Missed Connection Benefit.

22. A transfer of You or Your Traveling Companion by the employer by whom You or Your Traveling Companion are employed on Your Effective Date which requires their principal residence to be relocated.

23. Inclement Weather that causes complete cessation of services for at least 12 consecutive hours of the Common Carrier on which You are scheduled to travel;

Provided such circumstances occurred after Your Effective Date.

If You must reschedule the Covered Trip due to a covered reason they will be eligible for benefits up to a maximum of $250 for the reissue fee charged by the airline for the Insured's tickets.

Single Supplement

Benefits will be paid, up to the Maximum Benefit Amount, for the additional cost incurred as a result of a change in the per person occupancy rate for prepaid Travel Arrangements if a Traveling Companion has his or her Covered Trip delayed,

canceled or interrupted for a covered reason and an Insured does not cancel.

These benefits will not duplicate any benefits payable under the policy or any coverage(s) attached to the policy.

The Maximum Benefit Amount is shown in the Schedule of Benefits.

COVERAGE E
TRIP INTERRUPTION

This Coverage E is made a part of the policy. It is subject to all the provisions of this Coverage E.

Benefits will be paid, up to the Maximum Benefit Amount, for the non-refundable, unused portion of the prepaid expenses for Travel Arrangements and/or the Additional Transportation Cost paid to return home or rejoin the Covered Trip, when You are prevented from completing his or her Covered Trip due to:

1. Death involving You or Your Traveling Companion or You or Your Traveling Companions Business Partner or Your Family Member;

2. A covered Sickness or Injury involving You, Your Traveling Companion or Business Partner, or Your Family Member or Your Traveling Companion which necessitates Medical Treatment at the time of cancellation and results in medically imposed restrictions, as certified by a Legally Qualified Physician, which prevents an Insured's participation in the Covered Trip;

3. Your or Your Traveling Companion being hijacked, quarantined, required to serve on a jury (notice of jury duty must be received after the Effective Date) served with a court order to appear as a witness in a legal action in which You or Your Traveling Companion is not a party (except law enforcement officers);

4. You or Your Traveling Companion's principal place of residence being rendered uninhabitable by unforeseen circumstances or fire or flood or burglary of primary residence within 30 days of departure;

5. You or Your or Traveling Companion being directly involved in a traffic accident, which must be substantiated by a police report, while en route to an Insured's scheduled point of departure;

6. Bankruptcy or Default of an airline, or cruise line, or tour operator or travel supplier (other than the tour operator or travel agency from whom You purchased your travel arrangements) which stops service more than 14 days following Your Effective Date. Benefits will be paid due to Bankruptcy or Default of an airline only if no alternate transportation is available. If alternate transportation is available, benefits will be limited to the change fee charged to allow the Insured to transfer to another airline in order to get to the Insured's intended destination. This benefit only applies if the policy has been purchased within 21 days of the Insured's initial payment for the Covered Trip and for the full cost of the Covered Trip.

7. Unannounced strike that causes complete cessation of services of Your Common Carrier for at least 12 consecutive hours;

8. Strike that causes complete cessation of services of Your Common Carrier for at least 48 consecutive hours;

9. Weather that causes complete cessation of services of Your Common Carrier for at least 48 consecutive hours;

10. Natural disaster at the site of the Insured's destination, which renders their destination accommodations uninhabitable limited to the cost of the airfare of Your Covered Trip;

11. Felonious Assault on You or on Your Traveling Companion within 10 days of the scheduled Departure Date;

12. You or Your Traveling Companion is in the Military and called to emergency duty for a national disaster other than war;

13. Employer termination or layoff affecting You or a person(s) sharing the same room with You during Your Covered Trip. Employment must have been with the same employer for at least 1 continuous year;

14. A Terrorist Incident that occurs in a city listed on the itinerary of Your Covered Trip and within 30 days prior to Your Scheduled Departure Date. Benefits are not provided if the Travel Supplier offers a substitute itinerary.;

15. Revocation of Your previously granted leave or re-assignment due to war. Official written revocation/re-assignment by a supervisor or commanding officer of the appropriate branch of service will be required.;

16. Your family or friends living abroad with whom You were planning to stay are unable to provide accommodations due to life threatening illness, life threatening injury or death of one of them.

17. Your or Your Traveling Companion's place of employment is rendered unsuitable for business due to fire, flood, burglary or other Natural Disaster and You and/or Your Traveling Companion are required to work as a result.;

18. a documented theft of passports or visas;

19. a permanent transfer of employment of 250 miles or more.;

20. You, Your Traveling Companion or a Family Member traveling with You is required to work during the Trip. A written statement by an unrelated company official and/or the human resources department demonstrating revocation of previously approved time off will be required.

21. You, Your Traveling Companion or Family Member traveling with You are directly involved in the

merger of Your employer or the acquisition of Your employer by another company;

22. a cancellation of the Insured's Trip if the Insured's arrival on the Trip is delayed and causes the Insured to lose 50% or more of the scheduled Trip duration due to the reasons covered under the Missed Connection Benefit.

23. A transfer of You or Your Traveling Companion by the employer by whom You or Your Traveling Companion are employed on Your Effective Date which requires their principal residence to be relocated.

24. Inclement Weather that causes complete cessation of services for at least 12 consecutive hours of the Common Carrier on which You are scheduled to travel;

Provided such circumstances occurred after Your Effective Date.

COVERAGE F
BAGGAGE AND PERSONAL EFFECTS

This Coverage F Benefit is provided only if shown as covered in the Schedule of Benefits.
For the purposes of this Benefit:

"Baggage and Personal Effects" means goods being used by an Insured during a Covered Trip. The term Baggage and Personal Effects does not include:

1. animals;
2. automobiles and automobile equipment;
3. boats or other vehicles or conveyances;
4. trailers;
5. motors;
6. aircraft;
7. bicycles, except when checked as baggage with a Common Carrier;
8. household effects and furnishings;
9. antiques and collectors items;
10. sunglasses, contact lenses, artificial teeth, dental bridges or hearing aids;
11. prosthetic limbs;
12. prescribed medications;
13. keys, money, credit cards (except as coverage is otherwise specifically provided herein),
14. securities, stamps, tickets and documents (except as coverage is otherwise specifically provided herein);
15. professional or occupational equipment or property, whether or not electronic business equipment; or
16. telephones, computer hardware or software;

For Baggage and Personal Effects: Coverage will be provided to You: (a) against all risks of permanent loss, theft or damage to baggage and personal effects; (b) subject to all Exclusions and Limitations in the policy; (c) up to the Maximum Benefit Amount; and (d) occurring while this coverage is in force.

The lesser of the following amounts will be paid:

a) the actual cash value (cost less proper deduction for depreciation) at the time of loss, theft or damage;
b) the cost to repair or replace the article with material of a like kind and quality; or
c) $300 per article.

A combined maximum of $500 will be paid for jewelry, watches, articles consisting in whole or in part of silver, gold or platinum, articles trimmed with fur, cameras and their accessories and related equipment.

A maximum of $50 will be paid for the cost of replacing a passport or visa.

A maximum of $50 will be paid for the cost associated with the unauthorized use of lost or stolen credit cards, subject to verification that the Insured has complied with all conditions of the credit card company.

For Baggage Delay: If, while on a Covered Trip, Your checked baggage is delayed or misdirected by a Common Carrier for more than 24 hours from Your time of arrival at a destination other than at Your place of permanent residence, benefits will be paid, up to the Maximum Benefit Amount, for the actual expenditure for necessary personal effects. You must be a ticketed passenger on a Common Carrier. The Common Carrier must certify the delay or misdirection. Receipts for the purchases must accompany any claim.

Benefits will not be paid for any expenses which have been reimbursed or for any services which have been provided by the Common Carrier, hotel or Travel Supplier; nor will benefits be paid for loss or damage to property specifically schedule under any other insurance.

These benefits will not duplicate any benefits payable under the policy or any coverage(s) attached to the policy.

The Maximum Benefit Amount is shown in the Schedule of Benefits.

COVERAGE G
TRIP DELAY

This Coverage G Benefit is provided only if shown as covered in the Conformation of Benefits.

If You are delayed for 12 or more hours while in route to or from a Covered Trip, due to:

1. any delay of a Common Carrier. The delay must be certified by the Common Carrier;
2. a traffic accident in which You or Your Traveling Companion are not directly involved (must be substantiated by a police report);
3. lost or stolen passports, travel documents or money (must be substantiated by a police report); or
4. quarantine, hijacking, strike, natural disaster, terrorism or riot;
5. documented weather condition preventing the Insured from getting to the point of departure;

benefits will be paid, on a one-time basis, up to the Maximum Benefit Amount, for:

1. the Additional Transportation Cost from the point where You were delayed to a destination where he or she can join the Covered Trip;

2. the Additional Transportation Cost to return You to Your originally scheduled return destination;
3. reasonable accommodation and meal expenses necessarily incurred by You for which You have proof of purchase and which were not paid for or provided by any other source; and
4. the non-refundable, unused portion of the prepaid expenses for the Covered Trip as long as the expenses are supported by, proof of purchase and are not reimbursable by any other source.

Benefits will not be paid for any expenses, which have been reimbursed, or for any services that have been provided by the Common Carrier.

These benefits will not duplicate any benefits payable under the policy or any coverage(s) attached to the policy.

The maximum Benefit Amount is shown in the Schedule of Benefits.

COVERAGE H
EMERGENCY MEDICAL EVACUATION AND RETURN OF REMAINS

This Coverage H Benefit is provided only if shown as covered in the Schedule of benefits.

When You suffer loss of life for any reason or incurs a Sickness or Injury during the course of a Covered Trip, the following benefits are payable, up to the Maximum Benefit Amount.

1. For Emergency Medical Evacuation: If the local attending Legally Qualified Physician and the authorized travel assistance company determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment.

   If You are in the Hospital for more than seven consecutive days and Your dependent children who are under 18 years of age and accompanying You on the Covered Trip, are left unattended, Economy Transportation will be paid to return the dependents to their home (with an attendant, if considered necessary by the travel assistance company)."

   If an Insured is traveling alone and is in the Hospital for more than seven consecutive days and Emergency Evacuation is not imminent, upon request of the Insured, or next of kin if Insured is incapacitated, benefits will be paid to transport one person, chosen by the Insured, by Economy Transportation, for a single visit to and from his or her bedside.

2. For Medical Repatriation:
   a) If the local attending Legally Qualified Physician and the authorized travel assistance company determine that it is Medically Necessary for You to return to Your place of permanent residence because of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred will be paid for Your return to his or her permanent residence via:
      i) one-way Economy Transportation; or
      ii) commercial upgrade, based on an Insured's condition as recommended by the local attending Legally Qualified Physician and verified in writing.

      Transportation must be via the most direct and economical route.

   b) If the local attending Legally Qualified Physician and the authorized travel assistance company determine that it is Medically Necessary for You to return to his or her place of permanent residence for continued treatment of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred will be paid for transportation to the Hospital or medical facility closest to Your permanent place of residence capable of providing that treatment. Transportation must be by the most direct and economical route. Covered land or air transportation includes, but is not limited to, commercial stretcher, medical escort, or the Usual and Customary Charges for air ambulance, provided such transportation has been pre-approved and arranged by the authorized travel assistance company.

3. For Return of Remains: In the event of Your death, the expense incurred will be paid for minimally necessary casket or air tray, preparation and transportation of Your remains to his or her place of residence or to the place of burial.

Benefits are paid less the value of Your original unused return travel ticket.

If benefits are payable under this Coverage H and You have other insurance that may provide benefits for this same loss, the Company reserves the right to recover from such other insurance. You shall:
a) notify the Company of any other insurance;
b) help the Company exercise the Company's rights in any reasonable way that the Company may request, including the filing and assignment of other insurance benefits;
c) not do anything after the loss to prejudice the Company's rights; and
d) reimburse to the Company, to the extent of any payment the Company has made, for benefits received from such other insurance.

The Maximum Benefit Amount is shown in the Schedule of Benefits.

COVERAGE I
MISSED CONNECTION

If You miss Your cruise or tour departure because Your arrival at Your Trip destination is delayed for 3 or more hours, due to:
a) any delay of a Common Carrier (the delay must be certified by the Common Carrier);
b) documented weather condition preventing You from getting to the point of departure;
c) quarantine, hijacking, Strike, Natural Disaster, terrorism or riot.
We will reimburse You, up to the Maximum Benefit Amount shown in the Schedule of Benefits, for:

a) Your Additional Transportation Cost to join Your Trip ; and

b) Your Prepaid expenses for the unused land or water Travel Arrangements; and

c) reasonable accommodation and meal expenses necessarily incurred by You for which You have proof of purchase and which were not paid for or provided by any other source.

COVERAGE J
CHANGE FEE

The Company will pay a maximum of $250 for the fees associated with a change to Your air itinerary.

COVERAGE K
REIMBURSEMENT OF MILES OR REWARD POINTS

If You have Trip Cancellation Benefits under this Certificate and cancel Your Trip for a Covered Reason, benefits will be paid up to the Maximum Benefit Amount of $75 as shown in the Schedule of Benefits for any penalty cost of putting the miles or reward points back in the account they were removed from. This will not duplicate any benefits paid under the Trip Cancellation Benefit and is subject to the same General Exclusions and Limitations.

COVERAGE L
CANCEL FOR ANY REASON BENEFIT

Optional Coverage: Applicable only when purchased within 21 days of original plan purchase and if the appropriate additional premium has been paid.

If You cancel Your Trip for any reason not otherwise covered by this plan, benefits will be paid for 75% of the Prepaid, forfeited, non-refundable Payments or Deposits You paid for Your Trip provided:

a) Your payment for this plan is received within 21 days of the date Your initial Payment or Deposit for Your Trip is received; and

b) You insure 100% of the Prepaid Trip costs that are subject to cancellation penalties or restrictions and also insure within 21 days of the Payment or Deposit for those Travel Arrangements the cost of any subsequent Travel Arrangements (or any other Travel Arrangements not made through Your travel agent) added to Your Trip; and

c) You cancel Your Trip 48 hours or more before Your Scheduled Departure Date.

COVERAGE M
INTERRUPTION FOR ANY REASON BENEFIT

Optional Coverage: Applicable only when purchased within 21 days of original plan purchase and if the appropriate additional premium has been paid.

If You interrupt Your Trip, 48 hours or more after Your actual Departure Date, for any reason not otherwise covered by this plan, benefits will be paid, up to the lesser of a) the Maximum Benefit Amount shown in Your Schedule of Benefits; or b) 75% of the total amount of coverage You purchased, to reimburse You for the Prepaid Payments for unused non-refundable land, water or air Travel Arrangements:

a) to join Your Trip if You must depart after Your Scheduled Departure Date or travel via alternate travel arrangements by the most direct route possible to reach Your Trip destination; or

b) to rejoin Your Trip or transport You to Your originally scheduled return destination, if You must interrupt Your Trip after departure, each by the most direct route possible.

These benefits will not duplicate any other benefits payable under the Plan or any coverage(s) attached to the Plan.

SECTION II. DEFINITIONS

"Additional Transportation Cost" means the actual cost incurred for one-way Economy Transportation by Common Carrier reduced by the value of an unused travel ticket.
"Bankruptcy" means the filing of a petition for voluntary or involuntary bankruptcy in a court of competent jurisdiction under Chapter 7 or Chapter 11 of the United States Bankruptcy Code 11 L.S.C. Subsection 101 et seq.
"Business Partner" means an individual who (a) is involved in a legal general partnership with You and or (b) is actively involved in the day to day management of Your business.
"Common Carrier" means any land, sea, and/or air conveyance operating under a valid license for the transportation of passengers for hire.
"Covered Trip" means scheduled trips, tours or cruises for which (a) coverage is requested: and (b) the required premium is submitted prior to the Scheduled Departure Date.
"Default" means a material failure or inability to provide contracted services.
"Economy Transportation" means the lowest published available transportation rate for a ticket on a Common Carrier matching the original class of transportation that the Insured purchased for the Covered Trip.
"Family Member" means Your or a Traveling Companion's: legal spouse or common-law spouse where legal; legal guardian; son or daughter (adopted, foster or step); son-in-law; daughter-in-law; grandmother; grandmother-in-law; grandfather; grandfather-in-law; grandchild; aunt; uncle; niece; or nephew; brother, step-brother; sister; step-sister; brother-in-law; sister-in-law; mother; father; step-parent.
"Hospital" means (a) a place which is licensed or recognized as a general hospital by the proper authority of the state in which it is located: (b) a place operated for the care and treatment of resident inpatients with a registered graduate nurse (RN) always on duty and with a laboratory and X-ray facility: (c) a place recognized as a general hospital by the Joint Commission on the Accreditation of Hospitals. Not included is a hospital or institution licensed or used principally: (1) for the treatment or care of drug addicts or alcoholics: or (2) as a clinic continued or extended care facility, skilled nursing facility, convalescent home, rest home, nursing home or home for the aged.
"Inclement Weather" means any weather condition that delays the scheduled arrival or departure of a Common Carrier.
"Injury" or "Injuries" means accidental bodily injuries: (a) received while insured under the Policy and any attached coverages: (b) resulting in loss independently of sickness and all other causes: and (c) not excluded from coverage.
"Insured" means the person(s) named on the enrollment form or Roster as the Principal Participant, participant's spouse or participant's child.
"Intoxicated" mean a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where You are located at the time of an incident.

"Legally Qualified Physician" means a physician or a Christian Science Practitioner (a) other than You, a Traveling Companion or a Family Member: (b) practicing within the scope of Your license: and (c) recognized as a physician in the place where the services are rendered.

"Maximum Benefit Amount" means the maximum amount payable for coverage provided to an Insured as shown in the Schedule of Benefits.

"Medical Treatment" means treatment advice or consultation by a Legally Qualified Physician.

"Medically Necessary" means a service which is appropriate and consistent with the treatment of the condition in accordance with accepted standards of community practice.

"Pre-existing Condition" means any injury, sickness or condition (including any condition from which death ensues) of the Insured, or Traveling Companion, or Your and/or Traveling Companion's Family Member or Your Business Partner for which within the 60 day period prior to the effective date of Your Trip Cancellation coverage under the Policy which (a) manifested itself, became acute or exhibited symptoms which would have caused one to seek diagnosis, care or treatment; (b) required taking prescribed drugs or medicine, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or (c) required medical treatment or treatment was recommended by a Legally Qualified Physician.

"Published Penalties" means any published cancellation penalties issued by Your travel agency or travel supplier that apply to all clients of the travel agency or travel supplier and can be documented at time of trip sale. The maximum amount reimbursable under the travel agencies published penalties is 10% of the total trip cost excluding taxes and other non-commissionable items.

"Schedule of Benefits" means the coverage confirmation provided to You following enrollment and payment of the applicable premium.

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

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

"Sickness" means an illness or disease that is diagnosed or treated by a Legally Qualified Physician after the effective date of insurance and while You are covered under the Policy.

"Strike" means any stoppage of work: (a) as a result of a combined effort of workers which was unannounced and unpublished at the time travel services were purchased: and (b) which interferes with the normal departure and arrival of a Common Carrier.

"Third Party" means a person or entity other than You or the Company.

"Transportation Expense" means: (a) the cost of conveyance of You and any medical personnel (if Medically Necessary): and (b) Medically Necessary services or supplies.

"Travel Arrangements" means: (a) transportation: (b) accommodations: and (c) other specified services arranged by the Travel Supplier for the covered trip.

"Traveling Companion" means a person or persons with whom a covered person has coordinated travel arrangements and intends to travel with during the trip.

"Travel Supplier" means any entity or organization that coordinates or supplies travel services for You.

Usual and Customary Charges" means those comparable charges for similar treatment, services and supplies in the geographic area where treatment is performed.

SECTION III. INSURING PROVISIONS

Insured's Term of Coverage:

For Trip Cancellation: Coverage begins on the Effective Date and time specified in the Schedule of Benefits. Coverage ends at the point and time of departure on Your Scheduled Departure Date.

For Trip Delay: Coverage is in force while en route to and from the Covered Trip.

For all other coverages: Coverage begins at the point and time of departure on the Scheduled Departure Date. Coverage ends at the point and time of return on Your Scheduled Return Date.

In the event the Scheduled Departure Date and/or the Schedule Return Date are delayed, or the point and time of departure and/or point and time of return are changed because of circumstances over which neither the Travel Supplier nor You have control Your term of coverage shall be automatically adjusted accordance with the Travel Supplier's notice to the Company of the delay or change.

SECTION IV. GENERAL LIMITATIONS AND EXCLUSIONS

Benefits are not payable for Sickness, Injuries or losses of You, Your Traveling Companion or Your Traveling Companion's Family Member, or Your Business Partner:

1. resulting from suicide, attempted suicide or any intentionally self-inflicted injury while sane or insane (in Missouri, sane only);
2. resulting from an act of declared or undeclared war;
3. while participating in maneuvers or training exercises of an armed service;
4. while mountaineering (engaging in the sport of scaling mountains generally requiring the use of picks, ropes, or other special equipment);
5. while participating as a member of a team in an organized sporting competition;
6. while piloting or learning to pilot or acting as a member of the crew of any aircraft;
7. received as a result or consequence of being Intoxicated, as specifically defined in the policy, or under the influence of any controlled substance unless administered on the advise of a Legally Qualified Physician;
8. to which a contributory cause was the commission of or attempt to commit a felony or being engaged in an illegal occupation;
9. due to normal childbirth, normal pregnancy through the first 6 months of pregnancy or voluntarily induced abortion;
10. for dental treatment (except as coverage is otherwise specifically provided herein);
11. which exceed the Maximum Benefit Amount for each attached coverage as shown in the Schedule of Benefits: or;
12. due to a Pre-existing Condition, as defined in the Policy. The Pre-existing Condition Limitation does not apply to: (a) Emergency Medical Evacuation, Medical Repatriation and Return of Remains coverage;
13. due to a mental or nervous disorder, unless hospitalized.
14. due to loss or damage (including death or injury) and any associated cost or expense resulting directly from the discharge, explosion or use of any device, weapon or

material employing or involving chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act and regardless of any other sequence thereto.

Additional Limitations and Exclusions Specific to Baggage and Personal Effects

Benefits are not payable for any loss caused by or resulting from:

a) breakage of brittle or fragile articles;
b) wear and tear or gradual deterioration;
c) confiscation or appropriation by order of any government or custom's rule;
d) theft or pilferage while left in any unlocked vehicle;
e) property illegally acquired, kept, stored or transported;
f) Your negligent acts or omissions; or
g) property shipped as freight or shipped prior to the Scheduled Departure Date.

SECTION V. GENERAL PROVISIONS

Notice of Claim: Notice of claim must be reported within 20 days after a loss occurs or as soon as is reasonably possible. You or someone on Your behalf may give the notice. The notice should be given to the Company or designated representative and should include sufficient information to identify the Insured.

Claim Forms: When notice of claim is received by the Company or designated representative, forms for filing proof of loss will be furnished. If these forms are not sent within 15 days, the proof of loss requirements can be met by sending a written statement of what happened. This statement must be received within the time given for filing proof of loss.

Proof of Loss: Proof of loss must be provided within 90 days after the date of the loss or as soon as is reasonably possible. Proof must, however, be furnished no later than 12 months from the time it is otherwise required, except in the absence of legal capacity.

Time of Payment of Claims: The Company or its designated representative will pay the claim after receipt of acceptable proof of loss.

Payment of Claims: Benefits for loss of life are payable to the Principal Insured, who is the beneficiary for all other Insureds. If: (a) the Principal Insured predeceases You: and (b) a beneficiary is not otherwise designated by the Principal Insured benefits for loss of life will be paid to the first of the following surviving preference beneficiaries:

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

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

Other than for loss of life, if any benefit is payable to: (a) You or the Principal Insured's beneficiary who is minor or otherwise not able to give a valid release: or (b) the Principal Insured's estate: the Company may pay up to $1,000.00 to the Principal Insured's beneficiary or any relative to whom the Company finds entitled to the payment. Any payment made in good faith shall fully discharge the Company to the extent of such payment.

Legal Actions: No legal action for a claim can be brought against us until 60 days after we receive proof of loss. No legal action for a claim can be brought against us more than 3 years after the time required for giving proof of loss. This 3-year time period is extended from the date proof of loss is filed and the date the claim is denied in whole or in part.

Concealment and Misrepresentation: The entire coverage will be void, if before, during or after a loss, any material fact or circumstance relating to this insurance has been concealed or misrepresented.

Other Insurance with the Company: You may be covered under only one travel policy with the Company for each Covered Trip. If You are covered under more than one such policy, You may select the coverage that is to remain in effect. In the event of death, the selection will be made by the beneficiary or estate. Premiums paid (less claims paid) will be refunded for the duplicate coverage that does not remain in effect.

Subrogation: If the Company has made a payment for a loss under this coverage, and the person to or for whom payment was made has a right to recover damages from the Third Party responsible for the loss, the Company will be subrogated to that right. You shall help the Company exercise the Company's rights in any reasonable way that the Company may request: nor do anything after the loss to prejudice the Company's rights: and in the event You recover damages from the Third Party responsible for the loss, the Insured will hold the proceeds of the recover for the Company in trust and reimburse the Company to the extent of the Company's previous payment for the loss.

Additional Claims Provisions Specific to Baggage

Insured's Duties After Loss of or Damage to Property or Delay of Baggage: In case of loss, theft, damage or delay of baggage or personal effects, and Insured must:

a) take all reasonable steps to protect, save or recover the property:
b) promptly notify, in writing, either the police, hotel proprietors, ship lines, airlines, railroad, bus, airport or other station authorities, tour operators or group leaders, or any Common Carrier or bailee who has custody of Your property at the time of loss:
c) produce records needed to verify the claim and its amount, and permit copies to be made:
d) provide to the Company, within 90 days from the date of loss, a detailed proof of loss signed and sworn to: and
e) be examined, if requested.

Reductions in the Amount of Insurance: The applicable benefit amount will be reduced by the amount of benefits, if any, previously paid for any loss or damage under this coverage for this Covered Trip.

SECTION VI. COORDINATION OF BENEFITS

Applicability

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

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

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

Definitions

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

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

"Plan" does not include individual or family: (a) insurance contracts; (b) direct payment subscriber contracts; (c) coverage through HMO's; or (d) coverage under other prepayment, group practice and individual practice Plans.

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

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

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

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

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

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

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

"Claim" is a request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of: (a) services (including supplies); (b) payment for all or a portion of the expenses incurred; or (c) a combination of (a) and (b).

"Claim Determination Period" is the period of time, which must not be less, than 12 consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine: (a) whether over insurance exists; and (b) how much each Plan will pay or provide.

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

Order of Benefit Determination Rules

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

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

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

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

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

(a) Nondependent/Dependent Rule. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan that covers the person as a dependent.

(b) Longer/Shorter Length of Coverage Rule. The benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan that covered that person for the shorter time.

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

Effect on the Benefits of This Plan When it is Secondary

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

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts are needed. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to pay the Claim.

Facility of Payment

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

Right of Recovery

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

Non-complying Plans

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

(a) If This Plan is the Primary Plan, This Plan will pay its benefits on a primary basis;

(b) if This Plan is the Secondary Plan, This Plan will pay its benefits first, but the amount of the benefits payable will be determined as if This Plan were the Secondary Plan. In this situation, our payment will be the limit of This Plan's liability; and

(c) if the non-complying Plan does not provide the information needed by This Plan to determine its benefits within 30 days after it is requested to do so, we will assume that the benefits of the non-complying Plan are identical to This Plan and will pay benefits accordingly. However, we will adjust any payments made based on this assumption whenever information becomes available as to the actual benefits of the non-complying Plan.

Worldwide Assistance Services

The Travel Assistance feature provides a variety of travel related services. Services offered include:

• Medical or Legal Referral
• Inoculation Information • Hospital Admission Guarantee
• Translation Service • Lost Baggage Retrieval
• Passport/Visa Information • Emergency Cash Advance
• Bail Bond • Prescription Drug/Eyeglass Replacement
• ID Theft Resolution Service • Concierge Service • Political and Natural Disaster Evacuation

Payment reimbursement to the Assistance Company is Your responsibility.

24/7 Worldwide Assistance Services
Travel Assistance, Medical Emergency,
Concierge Service, Political and Natural Disaster
Evacuation and ID Theft Resolution Service
On Call International
888-268-2824 (within US)
OR CALL COLLECT:
603-328-1725
(From all other locations)

Travel assistance services are provided by an independent organization and not by United States Fire Insurance Company or Travel Insured International. There may be times when circumstances beyond the Assistance Company's control hinder their endeavors to provide travel assistance services. They will, however, make all reasonable efforts to provide travel assistance services and help You resolve Your emergency situation.

AVAILABILITY OF SERVICES

You are eligible for information and concierge services at any time after You purchase this plan. The Emergency Assistance Services become available when You actually start Your Covered Trip. Emergency Assistance, Concierge and Informational Services end the earliest of: midnight on the day the program expires; when You reach Your return destination; or when You complete Your Covered Trip. The Identity Theft Resolution Services become available on Your scheduled departure date for Your Covered Trip. Services are provided only for an Identity Theft event which occurs while on Your Covered Trip. Identity Theft Resolution does not guarantee that its intervention on behalf of You will result in a particular outcome or that its efforts on behalf of You will lead to a result satisfactory to You. Identity Theft Resolution does not include and shall not assist You for thefts involving non-US bank accounts.

IDENTITY THEFT RESOLUTION SERVICES

In the event of an Identify Theft event while on Your Covered Trip, Travel Insured's designated provider will provide you with the support and tools needed for You to restore Your identity to pre-event status. Assistance includes contacting Your creditors to notify them of the event and to request replacement cards; connecting you with a friend or family member at home and providing them with the assistance to set up a transfer or wire of funds; information on how to contact the three major credit bureaus; guidance on how to

obtain a police report; and providing You with a guide on how to restore Your credit.

CONCIERGE SERVICES

Concierge Services are provided by Travel Insured's designated provider. There is no charge for the services provided by the provider. You are responsible for the cost of services provided and charged for by third parties and for the actual cost of merchandise, entertainment, sports, tickets, food and beverages and other disbursement items. Services offered include: • Destination Profiles • Epicurean Needs • Event Ticketing • Floral Services • Tee Time Reservations • Hotel Accommodations • Meet-And-Greet Services • Shopping Assistance Services • Pre-Trip Assistance • Procurement of Hard-To-Find Items • Restaurant Referrals and Reservations • Rental Car Reservations • Airline Reservations

POLITICAL AND NATURAL DISASTER EVACUATION

If Participant requires emergency evacuation, which places him/her in Imminent Bodily Harm or due to a Natural Disaster, which makes his/her location Uninhabitable, or Participant's specific location in the Host Country is deemed Uninhabitable by the Assistance Company's Security Personnel, the Assistance Company will arrange and pay for evacuation from a safe departure point to the nearest safe location. The Assistance Company shall arrange and pay up to $100 per day up to a maximum of three (3) days for reasonable accommodations related to lodging if the Participant is delayed at the nearest safe location. The Assistance Company shall also arrange and pay for one-way economy airfare to return Participant to his/her Home Country following a Natural Disaster or Political Evacuation. Economy airfare and lodging costs shall not exceed a combined single limit of $5,000 USD per Participant. Participant must contact the Assistance Company as soon as possible after his/her Host Country issues the official disaster declaration, as delays may make safe transportation impossible. The method of transportation will be as deemed most appropriate to ensure Participant's safety. If evacuation becomes impractical due to hostile or dangerous conditions, the Assistance Company will maintain contact with and advise the Participant until evacuation becomes viable or the natural disaster situation or the political or social upheaval has been resolved. Should commercial transportation be available, but transportation to the commercial transportation departure point will place Participant in Imminent Bodily Harm, the Assistance Company shall arrange and pay for his/her secure transport to the departure point. Fees for commercial transportation and/or change fees are the responsibility of the Participant once he/she reaches the departure point where normal commercial transportation is available. There is a $100,000 CSL. Benefit is subject to the terms and conditions of the plan and as determined by ON CALL security personnel, in accordance with local and U.S. authorities. Services rendered without ON CALL's coordination and approval are not covered. No claims for reimbursement will be accepted. If the Participant is able to leave the Covered Person's host country by normal means, ON CALL will assist the Covered Person in rebooking flights or other transportation. Expenses for non-emergency transportation are the Covered Person's responsibility.

Claims Procedures

To facilitate prompt claims settlement:

TRIP CANCELLATION/TRIP INTERRUPTION: IMMEDIATELY Call Your Travel Supplier and Travel Insured International to report Your cancellation and avoid non-Covered Expenses due to late reporting. Travel Insured International will then advise You on how to obtain the appropriate form to be completed by You and the attending Physician. If You are prevented from taking Your Covered Trip due to Sickness or Injury, You should obtain medical care immediately. We require a certification by the treating Physician at the time of Sickness or Injury that medically imposed restrictions prevented Your participation in the Covered Trip. Provide all unused transportation tickets, official receipts, etc.

TRAVEL DELAY: Obtain any specific dated documentation, which provides proof of the reason for delay (airline or Cruise line forms, medical statements, etc). Submit this documentation along with Your Covered Trip itinerary and all receipts from additional expenses incurred.

MEDICAL EXPENSES: Obtain receipts from the providers of service, etc., stating the amount paid and listing the diagnosis and treatment.

BAGGAGE: Obtain a statement from the Common Carrier that Your Baggage was delayed or a police report showing Your Baggage was stolen along with copies of receipts for Your purchases.

Claims Administered by

TRAVEL INSURED Intl.

Quality Protection Worldwide

For questions or to report a claim, contact:

Travel Insured International, Inc.

P.O. Box 6503

Glastonbury, CT 06033

855-376-2040

STATE EXCEPTIONS

ARKANSAS: The Provision entitled "Legal Actions" is amended so that the "three year" period reads "five years or within the time allowed by law".

CONNECTICUT: The following provision is hereby added to the certificate:

THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS WILL BE PROVIDED TO YOU WHEN COVERAGE IS ELECTED.

Upon request, the master policy will be made available to any Certificateholder.

In the event of any cancellation of the master policy, adequate notice will be given to all certificate holders.

The Subrogation Provision is hereby revised as follows:

Subrogation: AS PERMITTED BY LAW: If the Company has made a payment for a loss under this coverage, and the person to or for whom payment was made has a right to recover damages from the Third Party responsible for the loss, the Company will be subrogated to that right. An Insured shall help the Company exercise the Company's rights in any reasonable way that the Company may request: nor do anything after the loss to prejudice the Company's rights: and in the event an Insured recovers damages from the Third Party responsible for the loss, the Insured will hold the proceeds of the recover for the Company in trust and reimburse the Company to the extent of the Company's previous payment for the loss.

Exclusion #9 is hereby deleted and replaced with the following:

received as a result or consequence of the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by is physician for the insured.

Exclusion # 12 is hereby deleted in its entirety.

Exclusion 16 is hereby deleted in its entirety.

The provision entitled "Excess Provision" has been deleted in its entirety.

The definition of Medical Necessity is hereby added as follows:

"Medical Necessity or Medically Necessary" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For the purposes of this section, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

The definition of Pre-existing condition is amended to read:

"Pre-existing Condition" means coverage that is excluded for twelve months following the insured's effective date of coverage for conditions, whether physical or mental, for which medical advise, diagnosis, care or treatment was recommended or received during the six months immediately preceding the effective date of coverage.

The following additional benefits apply to Connecticut residents. Benefits are subject to this Certificate's Policy Year, and Lifetime Maximum Benefits, Exclusions, Limitations and all other certificate provisions.

1. Isolation Care and Emergency Services- Benefits will be provided for isolation care and emergency services provided by the state's mobile field hospital. Such benefits are subject to any policy provisions that apply to other services covered.

2. Preventive Pediatric Care- Benefits are provided for preventive pediatric care for any child covered by the contract at approximately the following age intervals: Every two months from birth to six months of age, every three months from nine to eighteen months of age and annually from two through six years of age. Services rendered during a periodic review shall be covered to the extent that such services are provided by or under the supervision of a single physician during the course of one visit. Coverage shall also be provided for blood lead screening and risk assessments ordered by a primary care provider. Such benefits are subject to any policy provisions which apply to other services covered. For purposes of this section, "preventive pediatric care" means the period review of a child's physical and emotional health from birth through six years of age by or under the supervision of a physician. Such review shall include a medical history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards.

3. Accidental Ingestion of Controlled Drugs - Benefits will be paid for emergency medical care related to the accidental ingestion or consumption of a controlled drug for up to 60 inpatient hospital days and $10,000 of outpatient treatment each calendar year.

4. Emergency ambulance services Coverage- Coverage is provided for services whenever any person covered is transported when medically necessary by ambulance to a hospital. Such benefits shall be subject to any provision which applies to other services covered. Any

payment for emergency ambulance services under coverage required by this section shall be paid directly to the ambulance provider rendering such service if such provider has complied with the provisions of this subsection and has not received payment for such service from any other source. Benefits payable will equal the lesser of: (1) Billed charges, or; (2) the applicable rate(s) published by the Connecticut Department of Public Health

5. Experimental Treatments - Benefits will be paid for any experimental treatment or procedure that has successfully completed a Phase III clinical trial of the federal Food and Drug Administration. There are no drug benefits payable under this plan whether or not they are experimental.

6. Mental and Nervous Disorders - Benefits will be paid on the same basis as any other Sickness for the diagnosis and treatment of mental or nervous disorders. Mental or nervous disorders means those conditions defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". Mental or nervous conditions do not include: mental retardation, learning disorders, motor skills disorders, communication disorders, caffeine-related disorders, relational problems, and additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the Diagnostic and Statistical Manual of Mental Disorders.

7. Autism Spectrum Disorder Coverage- Coverage is provided for physical therapy, speech therapy and occupational therapy services for the treatment of autism spectrum disorders as set forth in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders to the extent such services are a covered benefit for other diseases and conditions.

8. Early Intervention Services - Benefits will be paid for early intervention services provided as part of an individualized family service plan pursuant to section 17a-248 to a Covered Person from birth through age 3 years. Benefits are limited to $3,200 per child per policy year and an aggregate benefit of $9,600 over the three-year period.

9. Hearing Aids - Benefits will be paid for hearing aids provided to Covered Persons age 12 years or younger. Benefits are subject to a maximum of $1,000 every 24 months.

10. Craniofacial Disorders - Benefits will be paid for medically necessary orthodontic appliances recognized by the American Cleft Palate & Craniofacial Association when provided for the treatment of craniofacial disorders for Covered Persons age 18 or younger. Benefits do not include care, treatment, or supplies that are considered "cosmetic" in nature.

11. Hypodermic Needles – Benefits will be paid for hypodermic needles and syringes when prescribed by a Doctor as defined.

12. Inpatient Dental Anesthesia - Benefits will be paid for general anesthesia, nursing and related hospital services provided in conjunction with inpatient or outpatient dental services if: (a) the Covered Person is determined by a dentist, in conjunction with a Doctor who specializes in primary care, to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a hospital, or (b) a Covered Person who has a developmental disability, as determined by a Doctor who specializes in primary care, places the person at serious risk.

13. Diabetes - Benefits will be paid for laboratory and diagnosis tests for all types of diabetes, including treatment, medically necessary equipment and drugs for insulin-dependent, insulin-using, gestational and non-insulin-using diabetics. Benefits will be payable for 80% of billed charges for prescription medication for treatment of diabetes including insulin and oral forms of medication as prescribed by the Covered Person's doctor.

14. Prostrate Cancer Screening - Benefits will be paid for prostate cancer screenings in all men over age 50 and for any man who is symptomatic, or whose biological father or brother has been diagnosed with prostate cancer. Benefits include appropriate laboratory and diagnostic tests, including a prostate specific antigen "PSA" test.

15. Lyme Disease - Benefits will be paid for the diagnosis and treatment of Lyme Disease, including up to 60 days inpatient and outpatient intravenous antibiotic therapy or up to 120 days of oral antibiotic therapy, or both. Additional benefits are available if medically necessary and recommended by a board certified rheumatologist, infectious disease specialist or neurologist.

16. Pain Management - Benefits will be paid for care and treatment provided by a pain management specialist and for pain treatment ordered by the specialist. Benefits include all means medically necessary to make a diagnosis and develop a treatment plan, including the use of necessary medications during a pain treatment procedure.

    "Pain" means a sensation in which a person experiences severe discomfort, distress, or suffering due to provocation of sensory nerves. "Pain management specialist" means a Doctor who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, neurologist, oncologist, or radiation oncologist with additional training in pain management.

17. Ostomy Appliances & Supplies - Benefits will be paid for ostomy, colostomy, ileostomy and urostomy appliances and supplies for up to $1,000 annually following ostomy, colostomy, ileostomy or urostomy surgery that is covered under this plan. These appliances and supplies include collection devices, irrigation equipment, skin barriers and skin protectors.

18. Colorectal Cancer Screenings - Benefits will be paid for an annual colorectal cancer screening that includes fecal occult blood tests, colonoscopy, flexible sigmoidoscopy or radiological imaging. Coverage will be in accordance with age, family history and frequency guidelines established by the American College of Gastroenterology.

19. Mammography - Benefits will be paid for mammographic exams subject to the following limits: a baseline mammogram for women age 35 to 39, and an annual mammogram for women age 40 and older. Comprehensive ultrasound screening of the breasts is covered if recommended as medically necessary by a Doctor.

20. Maternity & Postpartum Care For Complications of Pregnancy Only - Benefits will be paid for birth that results as a Complication of Pregnancy for at least 48 hours of inpatient maternity care for mother and newborn following a vaginal birth and up to 96 hours following caesarean section.

    Any decision to shorten the length of inpatient stay to less than that provided shall be made by the attending health care providers after conferring with the mother. If a mother and newborn are discharged prior to the inpatient length of stay provided above, coverage will be provided for a follow-up visit within 48 hours of discharge and an additional follow-up visit within 7 days of discharge.

    This follow-up services includes, but is not limited to: physical assessment of the newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system and the performance of any medically necessary and appropriate clinical tests. These services must be consistent with protocols and guidelines developed by attending providers or by national pediatric, obstetric and nursing professional organizations and must be provided by qualified health care personnel trained in postpartum maternal and newborn pediatrics.

21. Home Health Care - Benefits will be paid for up to 180 visits in any policy year.

    Home health care coverage consists of, but is not limited to: Part-time or intermittent nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse, if the services of a registered nurse are not available; Part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other than a registered or licensed practical nurse; Physical, occupational or speech therapy; Medical supplies, drugs and medicines prescribed by a Doctor an advanced practice registered nurse or a physician assistant; and laboratory services to the extent such charges would have been covered if the Covered Person had remained or had been confined in the hospital; and Medical social services (limited to $200 for those Covered Persons diagnosed to live 6 months or less).

22. Prescription Foods/Formula - Benefits will be paid for amino acid modified preparations and low protein modified food products when prescribed by a Doctor for the therapeutic treatment of inherited metabolic diseases. Benefits are also paid for specialized formulas when medically necessary and prescribed by a Doctor.

    "Inherited metabolic disease" includes a disease for which newborn screening is required under Connecticut Statute section 19a-55, as amended, and cystic fibrosis.

    "Low protein modified food product" means a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a Doctor."

    "Amino acid modified preparation" means a product intended for the dietary treatment of an inherited metabolic disease under the direction of a Doctor.

    "Specialized formula" means a nutritional formula for children up to age twelve that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific diseases."

23. Mastectomy & Lymph Node Dissection - Benefits will be paid for at least 48 hours of inpatient care following mastectomy or lymph node dissection. Additional benefit hours are available if medically necessary and recommended by a Doctor.

24. Developmental Needs of Children & Youth with Cancer - Benefits will be paid for neuropsychological testing ordered by a Doctor to the extent of any cognitive or developmental delays in such children due to chemotherapy or radiation treatment.

25. Preventive Pediatric Care - Benefits will be paid for preventive pediatric care from birth through age 6. Coverage includes a medical history, physical exam, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests based on prevailing medical standards.

26. Tumors, Leukemia and Reconstructive Breast Surgery – Benefits will be paid for:

    a. the treatment of leukemia, including outpatient chemotherapy;
    b. reconstructive surgery and the cost of any non-dental prosthesis, including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis;
    c. outpatient chemotherapy following surgical procedures in connection with the treatment of tumors; a wig, if prescribed by a licensed oncologist, for a patient who suffers hair loss as a result of chemotherapy; and
    d. costs of removal of any breast implant which was implanted on or before July 1, 1994, without regard to the purpose of the implantation, which removal is determined to be medically necessary.

    Benefits are limited to a 12-month benefit equal to:

    a. $1,000 for the cost of removal of any breast implant;
    b. $500 for the surgical removal of tumors;
    c. $500 for reconstructive surgery;
    d. $500 for outpatient chemotherapy;

e. $350 for a wig; and
f. $300 for prosthesis, except that for purposes of the surgical removal of breasts due to tumors, the benefit is $300 for each breast removed.

Benefits include the reasonable costs of reconstructive surgery on each breast on which a mastectomy has been performed, and reconstructive surgery on a non-diseased breast to produce a symmetrical appearance.

Reconstructive surgery includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

27. Clinical Trials - Benefits will be paid for the routine patient care costs associated with a Covered Person enrolled in a Phase III cancer clinical trial, but only to the extent that these charges are not covered by the trial itself.

The cancer clinical trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by the National Institutes of Health, a National Cancer Institute affiliated cooperative group or the federal Food and Drug Administration as part of an investigational new drug or device exemption; or the federal Department of Defense or Veterans Affairs. A clinical trial does not include any single institution cancer clinical trial conducted solely under the approval of an institutional review board of an institution, or any trial that is no longer approved by an entity identified above.

"Routine patient care costs" mean those medically necessary health care services that are incurred as a result of the treatment provided to a Covered Person during a cancer clinical trial that would otherwise be covered if they were not rendered pursuant the cancer clinical trial.

Routine patient costs include:

a. Services rendered by a Doctor;
b. Diagnostic or laboratory tests; and
c. Hospitalization or other services provided during the course of treatment in the cancer clinical trial for the condition treated, or for one of its complications that is consistent with the usual and customary standard of care and would be covered if the Covered Person was not enrolled in a cancer clinical trial.

Routine patient care costs do not include:

a. The cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration;
b. The cost of a non-health care service that a Covered Person may require as a result of the treatment being provided for the purposes of the cancer clinical trial;
c. Facility, ancillary, professional services and drug costs that are paid for by grants or funding for the cancer clinical trial;
d. Costs of services that are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis or are performed specifically to meet the requirements of the cancer clinical trial;
e. Costs that would not be covered under the Certificate for non-investigational treatments, including, but not limited to items excluded from coverage under the Certificate; and
f. Transportation, lodging, food, or any other expenses associated with travel to or from a facility providing the cancer clinical trial, for the Covered Person or any family member or companion.

28. Diabetic Self-Management - Benefits will be paid for outpatient diabetes self-management. Benefits are limited to:

a. 10 hours of counseling, nutritional guidance and training in the proper use of diabetic equipment and supplies for newly diagnosed diabetics;
b. 4 hours of medically necessary training and education for diabetics who require a change in his or her self-management program; and
c. 4 hours of medically necessary training and education due to the development of new techniques and treatment of diabetes.

29. Infertility - Benefits will be paid for medically necessary expenses for the diagnosis and treatment of infertility. This includes but is not limited to: ovulation induction, intrauterine insemination, invitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer. "Infertility" means that a Covered Person is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period.

Benefits are limited to:
a. a Covered Person up to age 40;
b. a Covered Person who has maintained coverage for twelve months;
c. a lifetime benefit of 4 cycles for ovulation induction;
d. a lifetime benefit of 3 cycles for intrauterine insemination; and
e. two cycles, with not more than two embryo implantations per cycle, for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer or low tubal ovum transfer, provided each fertilization or transfer will be considered as one cycle.

Benefits are further limited as follows:

a. For in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer, benefits are limited to those Covered Persons who have been unable to conceive or produce conception or sustain a successful pregnancy through any less expensive and medically viable infertility treatment or procedures covered under the Certificate. However, nothing in this item a. shall be construed to deny the coverage in this Item 25 to any individual who foregoes a

particular infertility treatment or procedure if the individual's doctor determines that such treatment or procedure is likely to be unsuccessful.

Infertility treatment or procedures must be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility

FLORIDA: The Provision, Legal Actions is deleted and replaced with the following:

Legal Actions: No legal action for a claim can be brought against us until 60 days after we receive proof of loss. No legal action for a claim can be brought against us more than 5 years after the time required for giving proof of loss. This 5-year time period is extended from the date proof of loss is filed and the date the claim is denied in whole or in part.

HAWAII: The provision entitled "Arbitration" is deleted in its entirety.

In the General Limitations and Exclusions section, the exclusion related to device, weapon or material employing or involving chemical, biological, radiological or similar agents is deleted in its entirety.

IDAHO: The definition of Hospital is amended to read:

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

1. is a duly licensed institution;
2. in return for compensation from its patients, is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick person by or under supervision of Physicians;
3. has organized departments of medicine and major surgery;
4. provides 24-hour nursing service by or under the supervision of registered graduate nurses; and
5. is not other than incidentally: a) a skilled nursing facility, nursing home, custodial care home, health resort, spa or sanatorium, place for rest, or place for the aged; b) a place for the treatment of mental Illness; c) a place for the treatment of alcoholism or drug abuse, place for the provision of hospice care; or d) a place for the treatment of pulmonary tuberculosis.

ILLINOIS:

1. The definition of Pre-existing Condition in the DEFINITIONS section is deleted and replaced with the following:

   "Pre-existing Condition" means any disease, illness, sickness, malady or condition of an Insured, or Traveling Companion, or the Insured's and/or Traveling Companion's Family Member, or the Insured's Business Partner for which

   Medical advice, diagnosis, consultation, or treatment was received from a Legally Qualified Physician within 24-months prior to the effective date of coverage; or

   Symptoms existed within 12-months prior to the effective date of coverage which, in the opinion of a Legally Qualified Physician, would indicate that the disease, illness, sickness, malady or condition probably began and manifested itself prior to the effective date of coverage and would cause a reasonable person to seek diagnosis, care, or treatment.

2. The following statement is added to GENERAL CLAIM PROVISIONS, the section titled Time of Payment Of Claims:

   All claims will be paid within 30-days after receipt of due written proof of loss. If we have not paid the claim within this timeframe, we will pay interest at the rate of 9% from the 30th day after receipt of all necessary proof of loss, to the date of payment. We will not pay interest amounting to less than one dollar.

   Except as stated herein, this Amendatory Endorsement does not change coverage in any other way and is subject to all provisions, terms, and conditions of the Policy. If there is a conflict between the Policy and this Amendatory Endorsement, the terms of this Amendatory Endorsement will govern.

MAINE: The exclusion related to Terrorist Events is deleted in its entirety.

MISSISSIPPI: The provision entitled "Legally Qualified Physician" is amended to read:

"Legally Qualified Physician" means a health care practitioner or a Christian Science Practitioner (a) other than an Insured, a Traveling Companion or a Family Member: (b) practicing within the scope of his or her license: and (c) recognized as a health care practitioner in the place where the services are rendered.

The provision entitled "Notice of Claim" is amended so that the "20 days" notice reads "30 days".

The provision entitled "Time of Payment of Claims" is amended to read:

Benefits payable for any loss will be paid within 45 days after receipt of due written proof of such loss. Benefits due are overdue if not paid within 45 days after the Company or We receive proof of loss and the necessary information to adjudicate the claim and the necessary medical information and other information essential for Us to administer any coordination of benefits and subrogation provisions. If such information is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within 45 days after the Company receives such proof. Any part or all of the remainder of the claim that is later supported by such proof is overdue if not paid within 45 days after the Company receives such proof. To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the claimant or beneficiary in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery.

If the claim is not denied for valid and proper reasons by the end of such period of 45 days, the Company must pay You interest on accrued benefits at the rate of one and one-half

percent (1 ½ %) per month on the amount of such claim until it is finally settled or adjudicated.

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

The Provision entitled "Physical Examination and Autopsy" is re-titled "Physical Examination" and amended to read:

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

The provision entitled "Subrogation" is amended to read:

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

MISSOURI: The definition of Hospital is amended to read:

Hospital means a facility that:

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

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

The definition of Pre-existing Condition is amended to read:

Pre-Existing Condition means any injury, sickness or condition of You, an Insured's Traveling Companion an Insured's Family Member booked to travel with him or her for which within the sixty (60) day period prior to the effective date of Trip Cancellation coverage under the Group Policy such person received diagnosis or treatment for such injury, sickness or condition.

The Pre-Existing Conditions exclusion is waived for You if the Insured enrolls You in the Group Policy at the time the Insured pays the deposit required for his or her Trip (or within 21 days of the initial deposit) and the Insured purchases the coverage under the Group Policy for the full cost of their Trip. Such an Injury or Sickness will continue to be a Pre- Existing Condition until the earlier of:

(a) the expiration of 12 consecutive months, beginning with the effective date of coverage for which You have not received any medical care, consultation, diagnosis, or treatment or have not taken any prescribed drug or medicine on account of such condition; or
(b) the expiration of 24 consecutive months, beginning with the effective date of coverage. Taking maintenance medications for a condition that is considered stable shall not be cause for Exclusion.

The Subrogation provision is deleted in its entirety.

The Legal Actions provision is amended to read:

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

The section entitled "General Limitations and Exclusions" is amended as follows: The exclusions related to the actual, alleged or threatened discharge, dispersal, seepage, migration, escape, release or exposure to any hazardous biological, chemical, nuclear radioactive material, gas, matter or contamination or loss or damage (including death or injury) and any associated cost or expense resulting directly or indirectly from the discharge, explosion or use of any device, weapon or material employing or involving nuclear fission, nuclear fusion or radioactive force, or chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act, regardless of any other cause or event contributing concurrently or in any other sequence thereto are amended so that they do not apply if considered a Terrorist Act.
With regard to medical expenses, the "Payment of Claims" provision is amended by the addition of the following provision:

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

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

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

MONTANA: The definition of Sickness is amended to read:

Sickness means an illness or disease, including pregnancy that is diagnosed or treated by a Physician after the effective date of insurance and while You are covered under the Group Policy.

The following provision is added to the General Provisions section:

Conformity with Montana statutes: The provisions of this certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this certificate.

In the General Limitations and Exclusions section, the exclusion related to pregnancy and childbirth is deleted in its entirety.

NEW HAMPSHIRE: The definition of "Family Member" is amended to read:

"Family Member" means an Insured's or a Traveling Companion's: legal spouse or common-law spouse where legal; legal guardian; son or daughter (adopted, foster or step); child placed for adoption with the Insured or Traveling Companion; son-in-law; daughter-in-law; grandmother; grandmother-in-law; grandfather; grandfather-in-law; grandchild; aunt; uncle; niece; or nephew; brother, step-brother; sister; step-sister; brother-in-law; sister-in-law; mother; father; step-parent.

The definition of "Hospital" is amended to read:

"Hospital" means (a) a place that operates according to law in the state where it is located; and b) a place operated for the care and treatment of resident inpatients with a registered graduate nurse (RN) always on duty and with a laboratory and X-ray facility: Not included is a hospital or institution licensed or used principally: (1) for the treatment or care of drug addicts or alcoholics: or (2) as a clinic continued or extended care facility, skilled nursing facility, convalescent home, rest home, nursing home or home for the aged.

"Proof of Loss" is amended to read:

Proof of Loss: Proof of loss must be provided within 90 days after the date of the loss or as soon as is reasonably possible.

NEW YORK: The following language is amended to read:

COVERAGE B
ACCIDENT MEDICAL EXPENSE

This Coverage B Benefit is provided only if shown as covered on the Schedule of Benefits.

For purposes of this benefit:

"Covered Expense" means expense incurred for services and supplies: (a) listed below; and (b) ordered or prescribed by a Legally Qualified Physician as Medically Necessary for diagnosis or treatment; which are limited to:

1. the services of a Legally Qualified Physician;
2. Hospital or ambulatory medical-surgical center services (this will also include expenses for a cruise ship cabin or hotel room, not already included in the cost of the Insured's Covered Trip, if recommended as a substitute for a hospital room for recovery of an Injury);
3. transportation furnished by a professional ambulance company to and/or from a Hospital; and prescribed drugs, prosthetics and therapeutic services and supplies.

Benefits will be paid for the Covered Expense incurred, up to the Maximum Benefit Amount, if an Insured incurs a Covered Expense as a result of an accidental Injury which occurs during the Covered Trip. Only Covered Expenses incurred during the Covered Trip will be reimbursed. Expenses incurred after the Covered Trip are not covered.

Benefits will include expenses for emergency dental treatment due to accidental Injury not to exceed $750.00.

Benefits will not be paid in excess of the Usual and Customary Charges.

Advance payment will be made to a Hospital, up to the Maximum Benefit Amount, if needed to secure an Insured's admission to a Hospital, because of a covered accidental Injury. The authorized travel assistance company will coordinate advance payment to the Hospital.

NEW YORK MANDATES: Under New York Law, certain mandated benefits are required to be provided under a medical expense policy. The Company will pay benefits as applicable to this program for such mandates.

The Maximum Benefit Amount is shown in the Schedule of Benefits.

COVERAGE C
SICKNESS MEDICAL EXPENSE

This Coverage C is made a part of the policy to which it is attached. It is subject to all policy provisions of this Coverage C.

For purposes of this benefit:

"Covered Expense" means expense incurred for services and supplies: (a) listed below; and (b) ordered or prescribed by a Legally Qualified Physician as Medically Necessary for diagnosis or treatment; which are limited to:

1. the services of a Legally Qualified Physician;
2. Hospital or ambulatory medical-surgical center services (this will also include expenses for a cruise ship cabin or hotel room, not already included in the cost of the Insured's Covered Trip, if recommended as a substitute for a hospital room for recovery of an Sickness);
3. transportation furnished by a professional ambulance company to and/or from a Hospital; and
4. prescribed drugs, prosthetics and therapeutic services and supplies.

Benefits will be paid for the Covered Expense incurred, up to the Maximum Benefit Amount, if an Insured incurs a Covered Expense as a result of Sickness which first manifests itself during the Covered Trip. Only Covered Expenses incurred during the Covered Trip will be reimbursed. Expenses incurred after the Covered Trip are not covered.

Benefits will include expenses for emergency dental treatment not to exceed $750.00.

Benefits will not be paid in excess of the Usual and Customary Charges.

Advance payment will be made to a Hospital, up to the Maximum Benefit Amount, if needed to secure an Insured's admission to a Hospital, up to the Maximum Benefit Amount, because of a covered Sickness. The authorized travel

assistance company will coordinate advance payment to the Hospital.

NEW YORK MANDATES: Under New York Law, certain mandated benefits are required to be provided under a medical expense policy. The Company will pay benefits as applicable to this program for such mandates.

The Maximum Benefit Amount is shown in the Schedule of Benefits.

Definitions:

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

(a) is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
(b) has organized departments of medicine and major surgery;
(c) has a requirement that every patient must be under the care of a physician or dentist;
(d) provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
(e) if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97, (42 USCA 1395xk);
(f) is duly licensed by the agency responsible for licensing such hospitals; and

Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

"Pre-Existing Condition" means the existence of symptoms in You, Your Traveling Companion that would ordinarily cause a prudent person to seek diagnosis, care or treatment within a 60 day period preceding the effective date of Your coverage, or a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a 60 day period preceding the effective date of Your coverage.

SOUTH CAROLINA: The provision entitled "Legal Actions" is amended so that the "three year" period reads "six years".

The provision entitled "Subrogation is amended to read:

Subrogation: If the Company has made a payment for a loss under this coverage, and the person to or for whom payment was made has a right to recover damages from the Third Party responsible for the loss, the Company will be subrogated to that right for not more than the amount of insurance benefits that the Company has paid previously in relation to THE Insured's Injury by the liable Third Party. An Insured shall help the Company exercise the Company's rights in any reasonable way that the Company may request: nor do anything after the loss to prejudice the Company's rights: and in the event an Insured recovers damages from the Third Party responsible for the loss, the Insured will hold the proceeds of the recover for the Company in trust and reimburse the Company to the extent of the Company's previous payment for the loss. Attorneys' fees and costs must be paid by the Company from the amounts recovered.

The provision entitled "Time of Payment of Claims" is amended to read:

Time of Payment of Claims: The Company or its designated representative will pay the claim within 60 days after receipt of acceptable proof of loss.

VERMONT: The following disclosure is added to the certificate as follows:

THIS TRAVEL PROGRAM IS A LIMITED BENEFIT PROGRAM. READ YOUR CERTIFICATE CAREFULLY.

The following provision is added to the General Provisions section:

Vermont law requires that insurance policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this endorsement, the civil union must be established in the state of Vermont according to Vermont law.

It is understood that policy definitions and provisions designating

- an insured
- named insured
- who is insured
- who is a named insured
- covered person(s)
- you and/or your
- spouse
- family member

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

In the General Limitations and Exclusions section, the exclusion related to racing is amended to include "only when racing in a professional capacity".

In the General Limitations and Exclusions section, the exclusions relating to mountaineering, skydiving, hang gliding, bungee cord jumping, scuba diving and the exclusion related to device, weapon or material employing or involving chemical, biological, radiological or similar agents are deleted in their entirety.

WEST VIRGINIA: The following exclusions are amended to read as follows:

14.due to a Pre-existing Condition, as defined in this policy. The Pre-existing Condition Limitation does not apply to: (a) Emergency Medical Evacuation, Medical Repatriation and Return of Remains coverage;

WISCONSIN: The provision entitled "Subrogation" is amended to read:

Subrogation: If the Company has made a payment for a loss under this coverage, and the person to or for whom payment was made has a right to recover damages from the Third Party responsible for the loss, the Company will be

subrogated to that right. An Insured shall help the Company exercise the Company's rights in any reasonable way that the Company may request: nor do anything after the loss to prejudice the Company's rights: and in the event an Insured recovers damages from the Third Party responsible for the loss, the Insured will hold the proceeds of the recover for the Company in trust and reimburse the Company to the extent of the Company's previous payment for the loss. No subrogation will take place until the Insured is made whole.

In the General Limitations and Exclusions section, the exclusion related to device, weapon or material employing or involving chemical, biological, radiological or similar agents is deleted in its entirety.

WYOMING: The provision entitled "Legal Actions" is amended so that the "three year" period reads "four years".