

Med Evac

WHY WORRY?
TRAVEL SMART.



Not available to Washington residents.

DESCRIPTION OF COVERAGE

Please check Your confirmation of coverage to determine which plan You purchased. The plan you purchase has unique coverage terms and may have different definitions. Please check Your documentation thoroughly.

Schedule of Coverages & Services	Maximum Benefits
PER PERSON:	
MEDEVAC ANNUAL PRODUCT	
Emergency Evacuation and	
Repatriation of Remains	Up to 2 per Eligible Persons
Escort Expense Limit	\$5,000
Accident & Sickness Medical Expense	\$25,000

PER-TRIP PRODUCT	
Emergency Evacuation and	
Repatriation of Remains	1 per Eligible Person/Trip
Escort Expense Limit	\$5,000
Accident & Sickness Medical Expense	\$25,000

PER FAMILY:	
MEDEVAC ANNUAL PRODUCT	
Emergency Evacuation and	
Repatriation of Remains	Up to 2 per Eligible Persons
Escort Expense Limit	\$5,000
Accident & Sickness Medical Expense	\$25,000

PER-TRIP PRODUCT	
Emergency Evacuation and	
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Worldwide Emergency Assistance Services

Travel Guard® Assist
24-hour LiveTravel Assistance
Concierge Services

IMPORTANT — Exclusions apply to certain medical conditions.

Plan is designed by Travel Guard International.

This Insurance, under policy AIC-TRVL-P (2/03) is underwritten by: Arch Insurance Company, with its principal place of business in New York, NY.

Policy terms and conditions are briefly outlined in this Description of Coverage. Complete provisions pertaining to this insurance are contained in the Master Policy on file with American Group Travel Trust, BankNewport as Trustee. The use of a Trust is not permitted in Kansas, New York, Oregon, Texas or Washington. In the event of any conflict between this Description of Coverage and the Master Policy, the policy will govern

- Coverage is valid only if premium has been paid -

PRODUCT NUMBER: 007915 3/05

In the event of a claim, please refer to the above Product Number.

Emergency Evacuation

The Insurer will pay benefits for covered expenses up to the maximum shown on the Schedule of Coverages and Services if an Injury or Sickness commencing during the course of the covered Trip results in the Eligible Person's necessary Emergency Evacuation. An Emergency Evacuation must be ordered by a legally licensed Physician who certifies that the severity of the Eligible Person's Injury or Sickness warrants an Emergency Evacuation.

Emergency Evacuation means:

- The Eligible Person's medical condition warrants immediate transportation from the place where the Eligible Person is injured or sick to the nearest Hospital where appropriate medical treatment can be obtained;
- After being treated at a local Hospital, the Eligible Person's medical condition warrants transportation to the United States where the Eligible Person resides, to obtain further medical treatment or to recover; or
- Both (a) and (b), above.

Covered Expenses are reasonable and customary expenses, up to the maximum, for necessary transportation, medical services, and medical supplies incurred in connection with the Eligible Person's Emergency Evacuation. All transportation arrangements made for the Eligible Person's evacuation must be by the most direct and economical route possible. Expenses for the Eligible Person's Emergency Evacuation must be:

- Recommended by the attending Physician;
- Required by the standard regulations of the conveyance transporting the Eligible Person;
- Verified and approved in advance by the Assistance Company.**

Expenses for medical services and supplies must be recommended by the attending Physician. Transportation means any land, water, or air conveyance required to transport the Eligible Person during an Emergency Evacuation. Transportation includes, but is not limited to, air ambulances, land ambulances, commercial flights, and private motor vehicles. The Insurer will not cover any expenses provided by another party at no cost to the Eligible Person or already included in the cost of the scheduled Trip. **All transportation must be authorized and arranged by the Assistance Company.**

Transportation of Dependent Children: If the Eligible Person is in the Hospital, the Insurer will return the Eligible Person's dependents, who are under 18 years of age and accompanying him/her on the scheduled Trip, to their home or to the domicile of a person nominated by the Eligible Person or the Eligible Person's next of kin, with an attendant if necessary.

Transportation of Spouse or Domestic Partner: If the Eligible Person is in the Hospital for more than seven (7) consecutive days or if the attending Physician certifies that due to the Eligible Person's Injury or Sickness, the Eligible Person will be required to stay in the Hospital for more than seven (7) consecutive days, or if the Eligible Person dies on the Trip and requires Repatriation of Remains, the Insurer will return the Eligible Person's spouse or Domestic Partner to their primary residence.

Transportation to Join the Eligible Person: If the Eligible Person is in a Hospital alone for more than seven (7) consecutive days or if the attending Physician certifies that due to the Eligible Person's Injury or Sickness, the Eligible Person will be required to stay in the Hospital for more than seven (7) consecutive days, upon request the Insurer will bring a person, chosen by the Eligible Person, for a single visit to and from his or her bedside.

To access Emergency Assistance, call
Assistance Company's operation center at:
1.800.826.1300
or call collect: 1.715.345.0505

Repatriation of Remains

The Insurer will pay reasonable covered expenses incurred to return the Eligible Person's body to his or her primary residence if the Eligible Person dies during the covered Trip. This will not exceed the maximum shown on the Schedule of Coverages and Services.

Covered expenses include, but are not limited to, expenses for embalming, cremation, minimally necessary coffins for transport, and transportation.

Accident and Sickness Medical Expense

The Insurer will pay benefits, up to the maximum shown on the Schedule of Coverages and Services, if as the result of an Injury or Sickness while on Your Trip, You incur, within one year of the date of the Accident or onset of the Sickness, necessary Covered Medical Expenses, provided You received initial treatment within 1 day of the date of the Accident or the onset of Sickness. Covered Medical Expenses are Medically Necessary services and supplies, which are recommended by the attending Physician. They include the services of a legally qualified Physician; charges for hospital confinement and use of operating rooms; charges for anesthetics (including administration), x-ray examinations or treatments, and laboratory tests; ambulance service, drugs, medicines, prosthetics and therapeutic services and supplies; emergency dental treatment for the relief of pain. The Insurer will not pay benefits in excess of the reasonable and customary charges commonly used by providers of medical care in the locality in which the care is furnished.

Make sure You call Travel Guard (1.800.826.1300 or 1.715.345.0505) before You seek medical care while traveling. Where available, we can arrange direct payment to a member of our Preferred medical network, saving You the time and paper work associated with reimbursement of medical expenses. By calling us first, we can authorize a cash advance for medical providers that require upfront payments. Our assistance coordinators also can help You locate the nearest and most appropriate medical provider, monitor Your care, and provide updates to Your family and/or employer.

Excess Insurance Provision

The insurance provided for Accident and Sickness Medical Expense shall be in excess of all other valid and collectible insurance or indemnity and shall apply when such other benefits are exhausted. (Not applicable to Illinois, Missouri or Texas residents)

Worldwide Emergency Assistance Services

The following services are not part of a filed insurance policy. All benefits provided are service benefits, not financial benefits. Any costs associated with benefits not purchased will be paid by the named Eligible Person. Non-insurance services through Travel Guard® Assist are provided by Travel Guard®.

All coverages and services may be subject to exclusion in areas or countries where travel restrictions, warnings or advisories are issued by the U.S. State Department.

TRAVEL GUARD® Assist

24-Hour Medical Assistance

24-Hour Medical Monitoring: Physicians monitor the Eligible Person's condition by maintaining close contact with the attending Physicians, his/her family Physician, and immediate Family Members.

Medical Evacuation: Arrangements for any and all means necessary to transport the Eligible Person back home when medically necessary.

Emergency Medical Payments: If a hospital demands a cash deposit or settlement prior to leaving, Travel Guard will assist in arranging the advancement of funds to cover on-site medical expenses.

Prescription Assistance: Replacement of lost or stolen medication, through a local pharmacy or special courier.

Transportation of Mortal Remains: In the event of death while traveling, arrangements and payment for the return of remains to the place of burial.

24-Hour Legal Assistance

In a legal emergency, referral to a local legal advisor and advance of funds for bail and legal fees.

24-Hour Travel Assistance

Travel Documents Assistance: Travel Guard will help retrieve, report, and reissue lost or stolen travel documents.

Emergency Cash Transfer: Travel Guard will, whenever possible, coordinate with the Eligible Person and a wire agency, in obtaining funds in local currency for medical or travel emergencies.

Emergency Message Center: Transmission of emergency messages to family and business associates.

Interpretation Services: Travel Guard will provide emergency language support or referral to the appropriate local services.

24-Hour LiveTravel Assistance

Provides 24-hour assistance for emergency travel needs. Allows the Eligible Person to make emergency travel changes such as rebooking flights, making hotel reservations, tracking lost luggage, and replacing lost credit cards. Call 1.800.826.8597 for assistance.

Pre-trip Travel Advice – Around-the-clock access to passport, visa, inoculation, and vaccine requirements; travel advisories; embassy and consulate contacts; travel health advisories; weather and currency information – all for the Eligible Person's planned destination.

Concierge Services

Restaurant Referrals and Reservations – Travel Guard will supply a restaurant referral based on the Eligible Person's needs and desires. Additionally Travel Guard will arrange for reservations at the recommended restaurant. Based on availability.

Ground Transportation – Travel Guard will locate and arrange for a transportation service to pick the Eligible Person up and deliver the Eligible Person to his/her desired destination.

Event Ticketing – Travel Guard will assist with the purchase of tickets to such events as sporting events, theatre, and concerts. Based on availability.

Tee Times and Course Recommendations – Travel Guard will facilitate the reservation of tee times at available courses and recommend alternatives in case of a booked course. Based on availability.

Floral Services – Travel Guard will facilitate the ordering of flowers for such events as birthdays, anniversaries, holidays, and other special occasions.

NOTE: Problems of distance, information and communication make it impossible for Arch Insurance Company or Travel Guard to assume any responsibility for the availability, quality, use or result of any emergency service. In all cases, the Eligible Person is still responsible for obtaining, using and paying for his or her own required services of all types.

24-Hour Emergency Assistance Telephone Numbers

Continental USA.....1.800.826.1300

International.....1.715.345.0505

LiveTravel 24-Hour Assistance.....1.800.826.8597

Be sure to use the appropriate country and city codes when calling.

- KEEP THESE NUMBERS WITH YOU WHEN YOU TRAVEL-

PRE-EXISTING CONDITIONS

Pre-Existing Conditions means the Insurer will not pay under any coverage for any claims arising from an injury, sickness, or other condition (including any condition from which death ensues) of the Eligible Person within the 180 day period before the Eligible Person's coverage began under this protection plan which: (a) first manifested itself or exhibited symptoms which would have caused one to seek diagnosis, care or treatment; (b) required taking prescribed drugs or medicine unless the condition for which the prescribed drugs or medicine is taken remains controlled without any change in the required prescription; (c) required medical treatment or treatment was recommended by a Physician.

Exclusions

The following exclusions apply. This plan does not cover any loss caused by or resulting from:

1. Pre-Existing Conditions as defined except Emergency Evacuation and Repatriation of Remains. The Eligible Person must not be disabled from travel at the time he or she pays the premium.
2. Suicide, attempted suicide or any intentionally self-inflicted injury while sane or insane (in Missouri, sane only) committed by the Eligible Person, Traveling Companion or Family Member, whether Eligible Person or not;
3. War, invasion, acts of foreign enemies, hostilities between nations (whether declared or not) civil war;
4. Participation in any military maneuver or training exercise;
5. Piloting or learning to pilot or acting as a member of the crew of any aircraft;
6. Mental or emotional disorders;
7. Participation as a professional in athletics;
8. Being under the influence of drugs or intoxicants unless prescribed by a Physician;
9. Commission or the attempt to commit a criminal act by the Eligible Person, Traveling Companion, or Family Member, whether Insured or not;
10. Participating in bodily contact sports; skydiving; hang gliding; parachuting; mountaineering; any race; bungee cord jumping; and speed contest;
11. Dental treatment (except as a result of Accidental Injury to sound, natural teeth within twelve (12) months of the Accidental Injury);
12. Any non-emergency treatment or surgery, routine physical examinations, hearing aids, eye glasses or contact lenses;
13. Pregnancy and childbirth (except for Complication of Pregnancy);
14. Curtailment or delayed return for other than covered reasons;
15. Any failure of a provider of travel related services (including any Travel Supplier) to provide the bargained-for travel services or to refund money due the Eligible Person;
16. Civil disorder or riot;
17. Traveling for the purpose of securing medical treatment;
18. Tuberculosis, Severe Acute Respiratory Syndrome or other chronic airborne pathogen; and
19. Injury or Sickness when traveling against the advice of a Physician.

MAXIMUM LIMITS OF LIABILITY. All limits are applied per Trip. The Insurer's maximum limit of liability resulting from the same occurrence will be \$10,000,000. If the loss for all Eligible Person's from such an occurrence exceeds \$10,000,000, the Insurer will pay each Eligible Person the proportion of the benefits stated which \$10,000,000 bears to the total loss of all persons the Insurer insures under all travel and flight insurance in force under this program.

Definitions

1. "Accident" means a sudden, unexpected, unusual, specific event, which occurs at an identifiable time and place, but shall also include exposure resulting from a mishap to a conveyance in which the Eligible Person is traveling.

2. "Common Carrier" means any land, sea, and/or air conveyance operating under a license for the transportation of passengers for hire.
3. "Complication of Pregnancy" means a condition whose diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy.
4. "Covered Medical Expenses" are Medically Necessary services and supplies, which are recommended by the attending Physician.
5. "Dependent Child(ren)" means the Eligible Person's child (or children), including an unmarried child, stepchild, legally adopted child or foster child who is: (1) less than age 19 and primarily dependent on the Eligible Person for support and maintenance; or (2) who is at least age 19 but less than age 23 and who regularly attends an accredited school or college; and who is primarily dependent on the Eligible Person for support and maintenance.
6. "Domestic Partner" means a person, at least 18 years of age, with whom the Eligible Person has been living in a spousal relationship with evidence of cohabitation for at least 10 continuous months prior to the Effective Date of coverage.
7. "Economy Airfare" means the lowest published rate for a one-way ticket.
8. "Eligible Person" means a citizen or resident of the United States who is covered under a Class of Eligible Persons shown on the Application and who has paid the required premium. For the Family Plan, this includes the person enrolled for coverage, the Eligible Person's spouse, Domestic Partner, and unmarried Dependent Children of the Eligible Person who are under 19 years of age (24 if a full-time student).
9. "Individual Coverage Term" means the period of time beginning when the Insured has been enrolled for coverage under the policy and for whom the required premium has been paid.
10. "Injury" means bodily injury caused by an Accident occurring while this policy is in force, and resulting directly and independently of all other causes in loss covered by the policy. The Injury must be verified by a Physician.
11. "The Insurer" means Arch Insurance Company.
12. "Medically Necessary" means that a treatment, service, or supply is: (1) essential for diagnosis, treatment or care of the Injury or Sickness for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician and performed under his or her care, supervision or order.
13. "Policy" shall mean this document, the Application and any endorsements, riders or amendments that will attach during the period of coverage.
14. "Physician" means a licensed practitioner of medical, surgical or dental services acting within the scope of his/her license. The treating Physician may not be the Eligible Person, a Traveling Companion, or a Family Member.
15. "Scheduled Departure Date" means: **For the Annual Plan:** The first day of any covered Trip taken during the Individual Coverage Term. **For the Per-Trip Plan:** The date on which the You are originally scheduled to leave on the Trip.
16. "Scheduled Return Date" means: **For the Annual Plan:** the last day of any covered Trip taken during the Individual Coverage Term. **For the Per Trip Plan:** the date on which You are originally scheduled to return to the point of origin or to a different final destination.
17. "Sickness" means illness or disease which is diagnosed and treated by a Physician on or after the effective date of the protection plan and while the Eligible Person is covered under this plan.
18. "Travel Supplier" means tour operator, cruise line, hotel etc. who has made the land and/or sea arrangements.
19. "Trip" means: **For the Annual Plan:** Any trip taken during the Individual Coverage Term. Travel must be more than 100 miles from the Eligible Person's primary residence. Maximum Trip duration is 90 days. **For the Per-Trip Plan:** The date of travel shown on Your membership confirmation letter for which You purchased this plan.

General Provisions

CONTRACT. The policy, applications, riders and endorsements, if any, make up the entire contract. No change in the policy is valid unless it is signed by an executive officer of the Insurer. No agent has the power to change this policy.

RECORDS. As required by the Insurer, the participating organization must keep a record of the insurance for all Insureds. The Insurer can inspect these records while coverage is in effect and for one year after it ends or until final adjustment and settlement of claims hereunder, whichever is later.

CLERICAL ERRORS. The Insurer will not deny or cancel coverage on an Insured because of clerical error by the participating organization or by the Insurer. After an error is found, the Insurer will take appropriate action. This may include adjusting, collecting or refunding premium.

CONTESTING THIS POLICY. The Insurer relies on statements made by the participating organization in the application. If there is no fraud, the participating organization's statements: (a) are considered representations and not warranties; and (b) will not be used to void the policy or reduce any claim.

The Insurer will not contest the policy after it has been in effect for two (2) years, except for fraud.

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

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

MISREPRESENTATION AND FRAUD. Coverage as to an Insured shall be void if, whether before or after a loss, the Insured has concealed or misrepresented any material fact or circumstance concerning this policy or the subject thereof, or the interest of the Insured therein, or if the Insured commits fraud or false swearing in connection with any of the foregoing.

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

ASSIGNMENT. This policy is not assignable but benefits may be assigned.

CANCELLATION AND NON-RENEWAL.

Cancellation by the Participating Organization or Insured:

The Participating Organization or Insured has the right to cancel this policy at any time by giving advance notice to the Insurer (stating when thereafter the cancellation shall be effective).

Cancellation by the Insurer:

The Insurer has the right to cancel this policy at any time and for any reason within the first sixty (60) days. The Insurer will mail all notice of cancellation thirty (30) days prior to the effective date of cancellation on a policy which has been in force sixty (60) days or less. A specific explanation for cancellation will be given. On a policy which has been in force sixty one (61) days or more, the Insurer will mail advance notice of cancellation sixty (60) days prior to cancellation.

After this policy has been in effect for sixty (60) days, it may be cancelled only for one of the following reasons: (a) Non-payment of premium; (b) The policy was obtained through a material misrepresentation; (c) Any participating organization or Insured violating any of the terms and conditions of the policy; (d) The risk originally accepted has measurably increased;

All notices of cancellation will be mailed to the last mailing address known by the Insurer for the named participating organization or Insured.

The Insurer will mail all notices of cancellation for nonpayment of premium ten (10) days in advance prior to cancellation.

Non-renewal by the Insurer:

The Insurer has the right to non-renew this policy effective on any annual policy anniversary date. All notices of non-renewal will be mailed to the participating organization or Insured at the last mailing address known to the Insurer, at least sixty (60) days prior to the effective date of non-renewal and shall provide a specific explanation of the reasons for non-renewal.

POLICY TERM. The period beginning on the effective date and continuing for a period indicated in the policy. The policy term shall automatically renew continuously for successive one year periods (policy anniversary date) thereafter until cancelled or non-renewed pursuant to the terms of this policy.

WHEN AN INSURED'S COVERAGE BEGINS. All coverage will take effect at 12:01 A.M. local time, at the location of the Insured, on the Scheduled Departure Date provided: (a) coverage has been elected; and (b) the required premium has been paid.

WHEN AN INSURED'S COVERAGE ENDS.

For the Annual Plan:

An Insured's coverage will end at 11:59 local time on the date which is the earliest of the following: (a) the date the policy is terminated, unless the Insured purchased insurance prior to the date of termination; (b) the time the policy terminates; (c) When the Insured is less than 100 miles from their primary residence; (d) Any Trip that exceeds 90 days.

For the Per Trip Plan:

An Insured's coverage will end at 11:59 local time on the date which is the earliest of the following: (a) the date the policy is terminated, unless the Insured purchased insurance prior to the date of termination; (b) the Scheduled Return Date as stated on the travel tickets; (c) the date the Insured returns to his/her origination point if prior to the Scheduled Return Date; (d) the date the Insured leaves or changes his/her covered Trip (unless due to unforeseen and unavoidable circumstances covered by the policy); (e) the time the policy terminates; (f) If the Insured extends the return date, coverage will terminate at 11:59 P.M., local time, at the location of the Insured on the Scheduled Return Date; (g) The date the Insured cancels their covered Trip;

EXTENDED COVERAGE. All coverage under the policy will be extended, if: (a) the Insured's entire Trip is covered by the policy; and (b) the Insured's return is delayed by inclement weather. If coverage is extended for the above reasons, coverage will end on the earlier of: (a) the date the Insured reaches his/her Return Destination; or (b) seven (7) days after the date the Trip was scheduled to be completed.

PREMIUMS. The Insurer provides insurance in return for premium payments. Premium must be remitted on behalf of the Insureds to the Insurer or to its authorized representative.

AMOUNT OF PREMIUM. The amount of premium due from the participating organization is calculated by multiplying the number of Insureds in each class by the amounts due for the benefits for that class and adding the total amounts due for each class. The amount of premium due for each Insured is obtained by adding the total rate charged for each benefit provided for that Insured.

MODE OF PREMIUM:

Insured: The required premium must be paid to the participating organization or its authorized representative prior to the Scheduled Departure Date of the covered Trip. *Participating Organization:* The Participating Organization will pay the premium according to the schedule noted in the travel protection policy application.

PREMIUM RATE CHANGE. The Insurer has the right to change premium rates on any premium due date. The Insurer will give the participating organization thirty one (31) days advance notice in writing of any such change. The Insurer can also change the rates when any change affecting rates is made in the policy.

ARBITRATION. Notwithstanding anything in this policy to the contrary, any claim arising out of or relating to this contract, or its breach, will be settled by arbitration

administered by the American Arbitration Association in accordance with its Commercial rules except to the extent provided otherwise in this clause. Judgment upon the award rendered in such arbitration may be entered in any court having jurisdiction thereof. All fees and expenses of the arbitration shall be borne by the parties equally. However, each party will bear the expense of its own counsel, experts, witnesses, and preparation and presentation of proofs. The arbitrators are precluded from awarding punitive, treble or exemplary damages, however so denominated. If more than one Insured is involved in the same dispute arising out of the same policy and relating to the same loss or claim, all such Insureds will constitute and act as one party for the purposes of the arbitration. Nothing in this clause will be construed to impair the rights of the Insureds to assert several, rather than joint, claims or defenses. **This section does not apply to Kansas residents.**

CLAIMS. Death claims will be paid to the Insured's estate, unless we receive a written request from the Insured designating a named beneficiary. All other claims will be paid to the Insured. In the event the Insured is a minor, incompetent or otherwise unable to give a valid release for the claim, the Insurer may make arrangement to pay claims to the Insured's legal guardian, committee or other qualified representative. Any payment made in good faith will discharge the Insurer's liability to the extent of the claim.

The claimant (either the Insured or someone acting for the Insured) must notify the Insurer or its designated agent in writing about the claim. Correspondence should be sent to the administrative office, at the address shown on the cover page of the policy or the Insurer's designated agent. Such notification should include the Insured's name, the participating organization's name and the policy number. The claimant should notify the Insurer within twenty (20) days after a covered loss occurs or as soon as reasonably possible.

NOTICE OF CLAIM. Written notice of claim must be given to the Insurer or its designated representative within twenty (20) days after a covered loss first begins or as soon as reasonably possible. Notice should include the Insured's name and policy number.

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

PAYMENT OF CLAIMS. The Insurer, or its designated representative, will pay a claim after receipt of acceptable proof of loss. Benefits for loss of life are payable to Insured's beneficiary. If a beneficiary is not otherwise designated by the Insured benefits for loss of life will be paid to the first of the following surviving preference beneficiaries: a) Your spouse; b) Your child or children jointly; c) Your parents jointly if both are living or the surviving parent if only one survives; d) Your brothers and sisters jointly; or e) Your estate.

All other claims will be paid to the Insured. In the event the Insured is a minor, incompetent or otherwise unable to give a valid release for the claim, the Insurer may make arrangement to pay claims to the Insured's legal guardian, committee or other qualified representative. All or a portion of all other benefits provided by this policy may, at the option of the Insurer, be paid directly to the provider of the service(s). All benefits not paid to the provider will be paid to the Insured. Any payment made in good faith will discharge the Insurer's liability to the extent of the claim.

The applicable benefit amount will be reduced by the amount of benefits, if any, previously paid by other Insurance policies. In no event will the Insurer reimburse the Insured for an amount greater than the amount paid by the Insured.

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

State Exceptions

CALIFORNIA RESIDENTS:

This plan contains disability insurance benefits or health insurance benefits, or both, that only apply during the covered trip. You may have coverage from other sources that already provides you with these benefits. You should review your existing policies. If you have any questions about your current coverage, call your insurer or health plan.

ILLINOIS RESIDENTS:

The following definitions are revised:

Letter (b) is deleted from the definition of "Pre-Existing Conditions"

The following definition is added:

"Intoxication" is that which is defined by the laws of the state where the loss or cause of loss was incurred.

The following Exclusion is deleted (10) participating in bodily contact sports. Exclusion (3) shall read: "War, invasion, hostilities between nations (whether declared or not) civil war;"

The following sections are added to General Provisions:

INSURANCE WITH OTHER COMPANIES. If there is other valid coverage, not with this company, providing benefits for the same loss on other than an expense incurred basis and of which this company has not been given written notice prior to the occurrence or commencement of loss, the only ability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the company had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined.

ARBITRATION. An arbitration provision is not a substitute for a person's right to maintain a legal action if they so desire; and in no way affects or limits a person's ability to take legal action in a court of law, prior to voluntarily agreeing to enter into an arbitration proceeding.

Any controversy or claim arising out of or relating to this contract, or the breach thereof, may be settled by arbitration. The arbitration will be conducted pursuant to the applicable rules of the American Arbitration Association and in accordance with the Uniform Arbitration Act within reasonable time limit (30 days after the parties agree to arbitrate their dispute is a reasonable time limit for selected and appointing independent arbitrators, 15 days is a reasonable time limit for an expedited review provision). The arbitration may be binding on both parties, but in all instances must be entered into on a voluntary basis. Arbitrators must be fair impartial, and free of any conflicts of interest or the appearance of a conflict of interest.

By voluntarily agreeing to enter into an arbitration proceeding, the parties should be aware and understand that they may be giving up certain rights to have their dispute settled in an by a court of law, except to the extent that Illinois law may provide for judicial review of arbitration proceedings.

TIME PAYMENT OF CLAIMS. Claims payable under this policy shall begin to be paid in period payments no later than the 30th day after the Insured received notice of a health care selection. All subsequent payments will be made in accordance with the monthly periodic cycle. Failure to pay within such period shall entitle the payee to interest at the rate of 9% per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. Any required interest payments shall be made within 30 days after the payment.

KANSAS RESIDENTS:

The Subrogation provision does not apply to medical, surgical, hospital, or funeral expenses.

Legal Actions is revised as follows: "No legal action for a claim can be brought against us more than five (5) years after the time required for giving proof of loss."

A Claim Forms provision was added: "The Insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent to the loss for which claim is made."

A Time of Payment of Claims provision was added to the policy: "Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof."

Excess Insurance limitation is revised as follows: "The company's liability for benefits payable on account of expense incurred, for any hospitalization, medical surgical, and other services resulting from covered Injury of the covered person, shall be limited to that part of the expense, if any, which is in excess of the total benefits payable for the same loss, on a provision of service basis or on an expense incurred basis under any medical or service contract, self-funded plan, automobile medical payment coverage, or any plan under federal, state or local law (except Medicaid). If one or more of the other policies, plans or service contracts provide benefits on an excess insurance or an excess coverage basis, benefits should be paid first by the company or service plan whose policy or service contract has been in effect for the longer period of time at date of such loss."

The definition of Family Member is revised to read "Family Member" means Your legal or common law spouse, Domestic Partner, parent, legal guardian, step-parent, grandparent, parents-in-law, grandchild, natural or adopted child, foster child, ward, step-child, children-in-law, brother, sister, step-brother, step-sister, brother-in-law, sister-in-law, aunt, uncle, niece, or nephew.

Exclusion #9 is revised to read: "Commission or the attempt to commit a criminal act."

MARYLAND RESIDENTS:

If this policy is financed by a premium finance company and we (the Insurer) or the premium finance company or the first named Eligible Person cancels the policy, the refund will be pro rata excluding any expense constant, administrative fee, or nonrefundable charge filed with and approved by the insurance commissioner.

MISSOURI RESIDENTS:

"Bodily Injury" means identifiable physical injury which: (a) is caused by an Accident, and (b) solely and independently of sickness, disease, or bodily infirmity, except illness resulting from, or medical or surgical treatment rendered necessary by such injury, is the direct cause of death or dismemberment of the Insured within twelve months from the date of the Accident. Subrogation is not permitted in Missouri.

NEW YORK RESIDENTS:

The definition of "Complication of Pregnancy" is revised to read: "Complications of Pregnancy" means: (1) conditions requiring hospital stays (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and (2) nonelective caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of which a viable birth is not possible.

The following exclusions are deleted: (7) Participation as a professional in athletics or underwater activities; (8) Being under the influence of drugs or intoxicants, unless prescribed by a Physician, unless results in the death of a non-traveling immediate Family Member; (9) Commission or the attempt to commit a criminal act.; (10) Participating in bodily contact sports; skydiving; hang-gliding; parachuting; mountaineering; any race; bungee cord jumping; and speed contest; (14) Curtailment or delayed return for other than covered reasons, (18) Tuberculosis, Severe Acute Respiratory Syndrome, or other chronic airborne pathogen.

“Domestic Partner” means a person who has registered as a domestic partner in a municipality that requires such registration or has provided the Insurer with a signed and notarized Affidavit of Partnership in municipality that do not require such registration. The Affidavit will attest to the following:

- (a) Each person is 18 years of age or older and is mentally competent to consent to contract,
- (b) Neither one is married to or legally separated from anyone else,
- (c) They are not related by blood in a manner that would bar marriage under the laws of the state of New York,
- (d) They have been living together on a continuous basis prior to the date of application, AND
- (e) Neither individual has been registered as a member of another domestic partnership within the last six months.

Residency and citizenship do not apply to and are not requirements for coverage in relation to Emergency Evacuation and Repatriation of Remains benefits.

The Repatriation benefit is limited to the cost of transporting the body. Coverage for “embalming, cremation and casket for transport” is deleted.

Exclusion #2 is revised to read: Suicide or attempted suicide or intentionally self-inflicted injuries.

Exclusion #16 is revised to read: Riot or insurrection.

The following exclusions are deleted: (7) Participation as a professional in athletics or underwater activities; (8) Being under the influence of drugs or intoxicants, unless prescribed by a Physician, unless results in the death of a non-traveling immediate Family Member; (9) Commission or the attempt to commit a criminal act.; (10) Participating in bodily contact sports; skydiving; hang-gliding; parachuting; mountaineering; any race; bungee cord jumping; and speed contest; (14) Curtailment or delayed return for other than covered reasons.

OREGON RESIDENTS:

Exclusion #3 is revised to read: “War or act of war (whether declared or not);”

Exclusion #2 is revised to read: “suicide, attempted suicide or any intentionally self-inflicted injury while sane or insane (in Missouri, sane only)”

Exclusion #9 is revised to read: “commission or the attempt to commit a criminal act”

Exclusion #16 is revised to read: “Participation in civil disorder or riot.”

The following General Provisions sections are deleted: Records, Clerical Errors, Contesting This Policy, Legal Actions, Controlling Law, Cancellation and Non-Renewal, Policy Term, Premium, Amount of Premium, Mode of Premium, Premium Rate Change, and Claims.

The following General Provisions sections have been revised:

MISREPRESENTATION AND FRAUD: All statements and descriptions in any enrollment form for this policy by or in behalf of You or any other Insured, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealments of facts and incorrect statements shall not prevent a recovery under the policy unless the misrepresentations, omissions, concealments of fact and incorrect statements: (a) Are contained in a written statement for the insurance policy, and a copy of such statement is attached to the insurance policy when issued; (b) Are shown by the Insurer to be material, and the Insurer also shows reliance thereon; and (c) Are either fraudulent or material either to the acceptance of the risk or to the hazard assumed by the Insurer.

ARBITRATION. Notwithstanding anything in this policy to the contrary, any claim arising out of or relating to this contract, or its breach, may be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial rules except to the extent provided otherwise in this clause. Arbitration is by mutual consent by all parties and Oregon courts will have jurisdiction over such arbitration. All fees and expenses of the arbitration shall be borne by the parties equally. However, each party will bear the expense of its own counsel, experts, witnesses, and preparation and presentation of proofs. The arbitrators are precluded from awarding punitive, treble or exemplary damages, however so denominated. If more than one covered person is involved in the same dispute arising out of the same policy and relating to the same loss or claim, all such covered persons will constitute and act as one party for the purposes of the arbitration. Nothing in this clause will be construed to impair the rights of the covered persons to assert several, rather than joint, claims or defenses.

NOTICE OF CLAIM: Written notice of claim must be given by the claimant (either You or someone acting on Your behalf) to the Insurer or its designated representative within fifteen (15) days after a covered loss first begins or as soon as reasonably possible. Notice should include Your name and the Plan Number. Notice should be sent to the Insurer’s administrative office, at the address shown on the cover page of the policy, or to the Insurer’s designated representative.

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the loss either You or the Insurer can make a written demand for an appraisal. Such request for appraisal will be by mutual consent and take place in Oregon according to Oregon law. After the demand, You and the Insurer will each select Your own competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount of the loss. If they do not agree, they will select an arbitrator. Any figure agreed to by 2 of the 3 (the appraisers and the arbitrator) will be binding. You pay for the appraiser selected by You. The Insurer will pay the appraiser they choose. You will share equally with the Insurer the cost for the arbitrator and the appraisal process.

TEXAS RESIDENTS:

The Legal Actions provision is revised to permit suits against the insurers within 2 years and one day after the loss.

The Cancellation and Nonrenewal provision is revised so that it states “The Insurer cannot cancel or refuse to renew a policy or contract of insurance based solely on the fact that the policyholder in question is an elected official.”

The following definitions are revised as follows:

“Pre-Existing Condition” means any injury, sickness or condition of the Eligible Person, Traveling Companion and the Eligible Person’s and/or Traveling Companion’s Family Member for which within the sixty (60) day period prior to the effective date under this policy 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 required medical treatment or treatment was recommended by a Physician. The Pre-Existing Conditions exclusion is waived if the Eligible Person enrolls in this policy at the time the Eligible Person pays the deposit required for their Trip (or within 15 days of the initial deposit) and the Eligible Person purchases this policy for the full cost of their Trip.

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

Medical Evacuation/Repatriation benefit has been revised so that pre-approval is not required and cannot be a reason for denial of the benefit, but a 50% or \$500 penalty is permitted.

FOR PLAN INQUIRIES OR INFORMATION ON FILING A CLAIM,
PLEASE CONTACT THE PLAN ADMINISTRATOR AT

Travel Guard
1145 Clark Street; Stevens Point, WI 54481

1.800.826.1300 or 1.715.345.0505

BENEFICIARY

The Eligible Person’s estate, unless written notice of a designated beneficiary is provided to the Plan Administrator.



24 HOUR EMERGENCY ASSISTANCE

Telephone Numbers

Continental USA: **1.800.826.1300**

International: **1.715.345.0505**

LiveTravel 24-Hour Assistance, Pre-Trip Advice,

Live Messaging: **1.800.826.8597**

Be sure to use the appropriate country and city codes when calling.