Lloyd's Certificate

This Insurance is effected with certain Underwriters at Lloyd's, London.

This Certificate is issued in accordance with the limited authorization granted to the Correspondent by certain Underwriters at Lloyd's, London whose syndicate numbers and the proportions underwritten by them can be ascertained from the office of the said Correspondent (such Underwriters being hereinafter called "Underwriters") and in consideration of the premium specified herein, Underwriters hereby bind themselves severally and not jointly, each for his own part and not one for another, their Executors and Administrators.

The Assured is requested to read this Certificate, and if it is not correct, return it immediately to the Correspondent for appropriate alteration.

All inquiries regarding this Certificate should be addressed to the following Correspondent:

SEVENCORNERS

303 Congressional Boulevard
Carmel, IN 46032
1-800-335-0611
317-575-2652
317-575-2659 FAX
www.sevencorners.com

CERTIFICATE PROVISIONS

1. Signature Required. This Certificate shall not be valid unless signed by the Correspondent on the attached Declaration Page.

2. Correspondent Not Insurer. The Correspondent is not an Insurer hereunder and neither is nor shall be liable for any loss or claim whatsoever. The Insurers hereunder are those Underwriters at Lloyd's, London whose syndicate numbers can be ascertained as hereinbefore set forth. As used in this Certificate "Underwriters" shall be deemed to include incorporated as well as unincorporated persons or entities that are Underwriters at Lloyd's, London.

3. Cancellation. If this Certificate provides for cancellation and this Certificate is cancelled after the inception date, earned premium must be paid for the time the insurance has been in force.

4. Service of Suit. It is agreed that in the event of the failure of Underwriters to pay any amount claimed to be due hereunder, Underwriters, at the request of the Assured, will submit to the jurisdiction of a Court of competent jurisdiction within the United States. Nothing in this Clause constitutes or should be understood to constitute a waiver of Underwriters' rights to commence an action in any Court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another Court as permitted by the laws of the United States or of any State in the United States. It is further agreed that service of process in such suit may be made upon Mendes and Mount; 750 Seventh Avenue; New York, NY 10019-6829 USA (for California residents, contact Eileen Ridley, FLWA Service Corp., c/o Foley & Lardner LLP, 555 California Street, Suite 1700, San Francisco, CA 94104-1520 USA), and that in any suit instituted against any one of them upon this contract, Underwriters will abide by the final decision of such Court or of any Appellate Court in the event of an appeal. The above-named are authorized and directed to accept service of process on behalf of Underwriters in any such suit and/or upon request of the Assured to give a written undertaking to the Assured that they will enter a general appearance upon Underwriters' behalf in the event such a suit shall be instituted.

Further, pursuant to any statute of any state, territory or district of the United States which makes provision therefor, Underwriters hereby designate the Superintendent, Commissioner or Director of Insurance or other officer specified for that purpose in the statute, or his successors in office, as their true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the Assured or any beneficiary hereunder arising out of this contract of insurance, and hereby designate the above-mentioned as the person to whom the said officer is authorized to mail such process or a true copy thereof.

5. Assignment. This Certificate shall not be assigned either in whole or in part without the written consent of the Correspondent endorsed hereon.

6. Attached Conditions Incorporated. This Certificate is made and accepted subject to all the provisions, conditions and warranties set forth herein, attached or endorsed, all of which are to be considered as incorporated herein.

No Insured Person (i) appears on the list of Specially Designated Nationals and Blocked Persons administered by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"), or other denied party lists maintained by the U.S. Government, the European Union ("EU"), United Nations ("UN") or the United Kingdom ("UK"); (ii) is resident or physically present in a country or territory subject to sanctions, prohibitions or restrictions administered by OFAC, the EU, the UN or the UK; or (iii) is a person who is otherwise the target of U.S., EU, UN or UK sanctions, laws or regulations such that the Underwriters cannot deal or otherwise engage in business transactions with such person. Whenever the coverage provided hereunder would be in violation of any U.S., EU, UN or UK sanctions, prohibitions or restrictions, such coverage shall be immediately null and void. The Underwriters may be compelled by law to seize premiums, deny services, or withhold claims payments if an Insured Person becomes subject to U.S., EU, UN or UK sanctions while this Certificate is in effect.

CERTIFICATE OF INSURANCE
DECLARATIONS

East-West Center II (CHIP)
ATR19-190623-01LS

This Declaration is attached to and forms part of certificate provisions

ITEM 1. NAMED INSURED AND MAILING ADDRESS

East-West Center II (CHIP)
1601 East-West Road
Honolulu, HI 96848

PRODUCING AGENT NAME AND MAILING ADDRESS

Collegiate Risk Management
110 Athens Street, Suite 200
Tarpon Springs, FL 34689

ITEM 2. POLICY PERIOD FROM: 06/23/2019 TO: 06/20/2020 TERM: 364 Days

[X] 12:01 A.M., Standard Time at your mailing address

Insurance is effective with **CERTAIN UNDERWRITERS AT LLOYD'S, LONDON.** The Binding Authority Reference Number is B0775RCB07419.

IN RETURN FOR THE PAYMENT OF THE PREMIUM, AND SUBJECT TO ALL THE TERMS OF THIS CERTIFICATE, WE AGREE WITH YOU TO PROVIDE THE INSURANCE AS STATED IN THIS CERTIFICATE.

THIS POLICY CONSISTS OF THE FOLLOWING COVERAGE PARTS FOR WHICH A PREMIUM IS INDICATED. THIS PREMIUM MAY BE SUBJECT TO ADJUSTMENT.

International Travel Medical Coverage:

	Daily Premium	Trust Fee	Daily Charge
Student	$4.85	2.0%	$4.95
Spouse	$14.01	2.0%	$14.29
Child	$7.21	2.0%	$7.35

Premium shown above, payable: **Mode**
In Advance

This certificate of Insurance is made and accepted subject to the foregoing stipulations and conditions together with such other provisions, agreement or conditions as may be endorsed or added here to.

Dated: 06/11/2019 By:_____
(Correspondent – James J. Krampen, Jr.)

STUDENT GROUP PLAN
Evidence of Benefits
East-West Center II

Administered By:
Seven Corners, Inc.
303 Congressional Blvd.
Carmel, IN 46032 USA

Quick Contacts

Hospital and Doctor Network: To locate a network facility, search online at www.sevencorners.com/help/find-a-doctor, contact Seven Corners Assist at the numbers shown below, or log onto WellAbroad.com. Seven Corners Assist must be contacted prior to Hospital admission and/or any Inpatient/Outpatient Surgeries.

Please see the Pre-Notification and Network section for details and requirements regarding notification and use of the network.
Use of the network does not guarantee benefits.

Claims – It is important to submit Your claims to Seven Corners quickly. To be considered, all claims must be submitted to the Seven Corners Claim Department within 90 days after the date of service.

Travel Assistance - To receive assistance worldwide, call Seven Corners Assist at the numbers below and provide them with Your ID Number. You are eligible to use any of the assistance services provided. We are open 24 hours/day, 365 days a year, staffed with multilingual personnel. Seven Corners Assist must be contacted for Emergency Medical Evacuation.

Seven Corners Assist - In the United States, Canada, and the Caribbean (Toll-free): 1-800-690-6295 or Collect Calls: 1-317-818-2808
Email: assist@sevencorners.com

The Company hereby insures all persons whose Application has been accepted by the Administrator, Seven Corners, on behalf of the Company and whose name is identified on the ID Card, subject to all of the exclusions, limitations and provisions as set forth herein and in the Master Policy of insurance issued by the Company. Coverage is afforded only with respect to the person, coverage, amounts and limits specified herein and as identified on the ID Card for the insurance requested on such Application and for which their specified plan costs has been paid to the Administrator.

Eligibility

International students, visiting faculty, scholars or other persons with F-1 or J-1 Visa status while actively engaged in educational activities or research related activities are automatically enrolled in this insurance plan prior to the commencement of their programs or required to enroll to satisfy insurance requirements, unless proof of comparable coverage is furnished.

Students/scholars must actively attend classes or actively engage in research activities for at least the first 21 days after the date for which coverage is purchased. The 31-day requirement that students actively attend class does not apply to participants in the U.S. for training programs less than 31 days. Home study, correspondence, Internet, and television (TV) courses do not fulfill the Eligibility requirements that the student/scholar actively attend classes. The Company maintains its right to investigate student/scholar status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Eligible students/scholars who do enroll may also insure their Dependents. Eligible Dependents are the spouse and unmarried children or a reciprocal beneficiary under 19 years of age who are not self-supporting. Dependent Eligibility expires concurrently with that of the Insured student or scholar

EFFECTIVE DATES AND TERMINATION DATES

Coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company for its authorized representative, whichever is later. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student/scholar or extend beyond that of the Insured student/scholar. Refund of premiums is allowed only upon entry into the armed forces.

The Policy is a Non-Renewable One Year Term Policy.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date.

SCHEDULE OF BENEFITS

All coverages and plan costs listed in this Evidence of Benefits are in U.S. Dollar amounts.

Schedule of Medical Expense Benefits – Injury and Sickness **Up to $100,000 Maximum Benefit Paid as Specified Below for Each Injury or Sickness** **$150 Deductible per Insured Person per Policy Year**	
Insured Student / Scholar only: The Policy Deductible will be waived, and benefits will be paid for 100% of Covered Medical Expenses incurred when treatment is rendered at the University Health Services (Manoa). Exclusion #26 will be waived for TB testing, and benefits paid for 100% of Covered Medical Expenses for TB Testing at University Health Services (Manoa). The policy provides benefits for 80% of the URC Charges incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of $100,000 for each injury or Sickness. Benefits will be paid up to the Maximum Benefit for each service as scheduled below. Covered Sickness up to the Maximum Benefit of $100,000 for each injury or Sickness. Benefits will be paid up to the Maximum Benefit for each service as scheduled below. Covered Medical Expenses include:	
INPATIENT	
Room and Board Expense, daily semi-private room rate; and general nursing care provided by the Hospital	80% of URC Charges
Hospital Miscellaneous Expense, such as the cost of operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs or medicines, therapeutic services, and supplies. In computing the number of day's payable under this benefit, the date of admission will be counted, but not the date of discharge.	80% of URC Charges
Intensive Care	2x amount payable under Room and Board Expense
Routine Well-Baby Care, while Hospital Confined and routine nursery care provided immediately after birth.	Paid as any other Sickness / 4 days Hospital Confinement expense maximum
Physiotherapy	80% of URC Charges
Surgeon's Fees, in accordance with data provided by Ingenix. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures	80% of URC Charges
Anesthetist, professional services in connection with inpatient surgery	25% of Surgery Allowance
Registered Nurse's Services	**No Benefits**
Physician's Visits, benefits do not apply when related to surgery.	80% of URC Charges / $50 maximum per day Limited to one visit per day
Pre-Admission Testing, payable within 3 working days prior to admission	80% of URC Charges
Psychotherapy, psychiatric Hospitals are not covered.	Paid as any other Sickness / 30 days Limited to one visit per day
OUTPATIENT	
Surgeon's Fees, in accordance with data provided by Ingenix. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. URC Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	80% of URC Charges
Anesthetist, professional services administered in connection with outpatient surgery	25% of Surgery Allowance
Physician's Visits, benefits for Physician's Visits do not apply when related to surgery or Physiotherapy. **Per visit Deductible is in addition to the Policy Deductible**	80% of URC Charges/ $10 Deductible per visit Limited to one visit per day
Physiotherapy, see exclusion number 20 for limitations.	Limited to one visit per day
Medical Emergency Expenses, use of emergency room and supplies. Twenty-four hours a day, seven days a week to Insureds with emergency medical conditions without regard to whether the Insured, or an emergency provider treating the Insured, obtained prior authorization for these services. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. **Per visit Deductible is in addition to the Policy Deductible.**	80% of URC Charges / $50 Deductible per visit
Diagnostic X-Ray Services and Laboratory Services	80% of URC Charges
Tests and Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, X-Rays and Lab Procedures	80% of URC Charges
Radiation Therapy & Chemotherapy	80% of URC Charges

Injections	80% of URC Charges
Prescription Drugs	80% of URC Charges/$20 Deductible per Prescription
Psychotherapy, including all related or ancillary charges incurred as a result of a Mental & Nervous Disorder (including Prescription Drugs).	Paid as any other Sickness/24 visits maximum Limited to one visit per day
OTHER	
Ambulance Services	80% of URC Charges
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	80% of URC Charges
Consultant Physician Fees, when requested and approved by the attending Physician	80% of URC Charges
Alcoholism / Drug Abuse	Paid under Psychotherapy
Dental Treatment, made necessary by Injury to Sound, Natural Teeth	80% of URC Charges/$250 maximum
Maternity	Paid as any other Sickness
Elective Abortion	80% of URC Charges / $250 maximum
Complications of Pregnancy	Paid as any other Sickness

Maternity Testing

This policy does not cover routine, preventative or screening examinations or testing unless Medical Necessity is established based on medical records. The following maternity routine tests and with screening exams will be considered, if all other policy provisions have been met. This includes a pregnancy test, CBC, Hepatitis B Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, AFP Blood Screening, Pap Smear, and Glucose Challenge Test (at 24-28 weeks gestation). One Ultrasound will be considered in every pregnancy, without additional diagnosis. Any subsequent ultrasounds can be considered if a claim is submitted with the Pregnancy Record and Ultrasound report that establishes Medical Necessity. Additionally, the following tests will be considered for woman over 35 years of age: Amniocentesis/AFP Screening and Chromosome Testing. Fetal Stress/ Non-Stress tests are payable. Pre-natal vitamins are not covered.

Emergency Medical Evacuation/Repatriation

The plan will pay Covered Expenses incurred up to a maximum of $50,000 if any covered Injury or Illness commences during the Period of Coverage that results in the Medically Necessary Emergency Medical Evacuation or Repatriation (Your medical condition warrants immediate transportation from the medical facility where You are located to the nearest adequate medical facility where medical Treatment can be obtained). This benefit must be approved and arranged by the Assistance Company in consultation with the local attending Physician. Emergency Medical Evacuation or Repatriation means: a) the Insured Person's medical condition warrants immediate transportation from the medical facility where the Insured Person is located (due to inadequate medical facilities) to the nearest adequate medical facility where medical Treatment can be obtained; or b) after being treated at a local medical facility as a result of a covered Emergency Medical Evacuation, the Insured Person's medical condition warrants transportation with a qualified medical attendant to his/her Home Country to obtain further medical Treatment or to recover; or c) both a) and b) above. All transportation arrangements must be by the most direct and economical route.

MANDATED BENEFITS

Benefits for Child Health Services

Benefits will be provided on the same basis as any other Sickness for child health supervision services for Dependent children from the moment of birth through age five years. These services shall be exempt from any deductible provisions, and immunizations shall be exempt from any copayment provisions, which may be in force in these policies or contracts.

Child health supervision services shall include twelve visits at approximately the following intervals: birth; two months; four months; six months; nine months; twelve months; fifteen months; two years; three years; four years; and five years; covered at each visit shall include a history, physical examination, developmental assessment, anticipatory guidance, immunizations, and laboratory tests, in keeping with prevailing medical standards. The term "prevailing medical standards" means the recommendations of the Immunizations Practices Advisory Committee of the U.S. Department of Health and Human Services and the American Academy of Pediatrics; provided that in the event the recommendations of the committee and the academy differ, the department of health shall determine which recommendations shall apply.

Benefits are limited to one visit payable to one provider for all of the services provided at each visit stated above, except that the limitation shall not apply to immunizations.

Benefits for Mammography

Benefits will be provided on the same basis as any other Sickness for screening by Low-Dose Mammography for occult breast cancer as follows:

a) For Insureds forty years of age and older, an annual mammogram; and
b) For an Insured of any age with a history of breast cancer or whose mother or sister has had a history of breast cancer, a mammogram upon the recommendation of the Insured's Physician.

The term "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the x-ray tube, filter, compression device, screen, films, and cassettes, with an average radiation exposure delivery of less than one raid mid-breast, with two views for each breast.

The benefits provided are subject to all Deductible, coinsurance, copayments, limitations, or any other provisions in the Policy.

Benefits for Medical Foods and Low Protein Modified Food Products

Benefits will be for 80% of the actual expenses incurred for Medical Foods and Low-protein Modified Food Products for the treatment of an Inborn Error of Metabolism provided that the Medical Food or Low Protein Modified Food Product is:

1) Prescribed as Medically Necessary for the therapeutic treatment of an inborn error of metabolism; and

2) Consumed or administered eternally under the supervision of a Physician licensed under Hawaii Statutes chapter 453 or 460.

"Inborn error of metabolism" means a disease caused by an inherited abnormality of the body chemistry of a person that is characterized by deficient metabolism, originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate, or fat.

"Low-protein modified food product" means a food product that:

1) Is specially formulated to have less than one gram of protein per serving;
2) Is prescribed or ordered by a Physician as Medically Necessary for the dietary treatment of an inborn error of metabolism; and
3) Does not include a food that is naturally low in protein

"Medical food" means a food that is formulated to be consumed or administered internally under the supervision of a Physician and is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

The benefits provided are subject to all Deductible or any other provisions in the Policy.

Benefits for Diabetes

Benefits will be provided on the same basis as any other Sickness for outpatient diabetes self-management training, education, equipment, and supplies, if:

1) The equipment, supplies, training, and education are Medically Necessary; and
2) The equipment, supplies, training, and education are prescribed by a health care professional authorized to prescribe.

Benefits shall be subject to all Deductible, coinsurance, copayments, limitations, or any other provisions of the policy.

DEFINITIONS

Injury means bodily injury which is: 1) directly and independently caused by specific accidental Contact with another body or object; 2) unrelated to any pathological, functional, or structural Disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Insured Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms.

Master Policy means that certain group insurance policy, No. RCB07419 issued to World Commercial Trust by Certain Underwriters at Lloyd's, London, which is available upon request from Seven Corners.

Pre-Existing Condition means: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which originates, is diagnosed, treated or recommended for treatment within the 6 months immediately prior to the Insured's Effective Date under the policy.

Sickness means sickness or disease of the Insured Person which causes loss and originates while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

Usual, Reasonable and Customary (URC) Charges means a reasonable charge which is: 1) Usual, Reasonable and Customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual, Reasonable and Customary Charges.

EXCLUSIONS AND LIMITATIONS

No benefits will be paid for loss or expense (a) caused by, contributed to, or resulting from, or b) treatment, services, or supplies for, at or related to:

1. Acne; acupuncture; allergy, including testing;
2. Addiction such as: nicotine addiction, caffeine addiction; non-chemical addictions, such as gambling, sexual, spending, shopping, working and religious;
3. Assistant Surgeon Fees;
4. Hyperkinetic syndromes, milieu therapy, learning disabilities, behavioral problems, parent-child problems, attention deficit disorder, conceptual handicap, developmental delay or disorder or mental retardation;
5. Biofeedback
6. Circumcision;
7. Congenital conditions, expect as specifically provided for Newborn or adopted infants;
8. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children; non-malignant warts, moles, and lesions;
9. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
10. Elective Surgery and Elective Treatment
11. Eye examinations, prescriptions or fitting of eyeglasses or contact lenses; except when due to a disease process;
12. Foot care including: care of corns, bunions (except capsular or bone calluses)
13. Injury sustained while (a) participating in any interscholastic, club, intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest, or competition;
14. Hearing, examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
15. Hirsutism; alopecia;
16. Immunizations, except as specifically provided in the policy; preventative medicines or vaccines, except where required for treatment of a covered Injury;

17. Injury caused by, contributed to, or resulting from the use of alcohol, intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;
18. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
19. Organ transplants;
20. Outpatient Physiotherapy; except for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation;
21. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
22. Pre-existing Conditions, except for individuals who have been continuously insured under the school's policy for at least 6 consecutive months;
23. Prescription Drug Services, services or supplies as follows; except as specifically provided:
    a) Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use;
    b) Birth control and/or contraceptives, oral or other, whether medication or device, regardless of intended use;
    c) Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
    d) Drugs labeled, "Caution – limited by federal law to investigational use" or experimental drugs;
    e) Products used for cosmetic purposes;
    f) Drugs used to treat or cure baldness; anabolic steroids used for body building;
    g) Anorectics – drugs used for the purpose of weight control
    h) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
    i) Growth hormones; or
    j) Refills in excess of the number specified of dispensed after one (1) year of date of the prescription;
24. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services, or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery;
25. Routine Newborn Infant care, well-baby nursery and related Physician charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;
26. Routine physical examinations and routine testing; preventative testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
27. Services provided by the Health Service of the Policyholder; or services covered or provided by the student health fee;
28. Nasal and sinus surgery;
29. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planning, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
30. Sleep disorders
31. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
32. Supplies, except as specifically provided in the Policy;
33. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia;
34. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
35. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and
36. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat and treatment of eating disorders such as bulimia and anorexia. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.

POLICY PROVISIONS

1. Notice of Claim: Written notice of claim must be given to the Underwriter within 90 (ninety) days after the occurrence or commencement of any Disablement covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Administrative Offices of the Underwriter, or to any authorized agent of the Underwriter, with information sufficient to identify the Insured Person shall be deemed notice to the Underwriter.
2. Claim Forms: The Underwriter, 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 fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the requirements of the 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 of the Disablement for which claim is made.
3. Proof of Loss: Written Proof of Loss must be furnished to the Underwriter at its said office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 (ninety) days after the termination of the period for which the Underwriter is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.
4. Time of Payment of Claims: Indemnities payable under the Policy for any loss other than loss for which the 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 the Policy provides periodic payment will be paid at the expiration of each four (4) weeks during the continuance of the period for which the Underwriter is liable, and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

5. Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Insured Person. Any other accrued indemnities unpaid at the Insured Person's death may, at the option of the Underwriter, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Insured Person. If any indemnity of the Policy shall be payable to the estate of an Insured Person, or to an Insured Person who is a minor or otherwise not competent to give a valid release, the Underwriter may pay such indemnity, up to an amount not exceeding $1,000, to any Relative by blood or connection by marriage of the Insured Person who is deemed by the Underwriter to be equitably entitled thereto. Any payment made by the Underwriter in good faith pursuant to this provision shall fully discharge the Underwriter to the extent of such payment.
   Subject to any written direction of the Insured Person all or a portion of any indemnities provided by this Policy on account of Hospital, nursing, medical or Surgical service may, at the Underwriter's option and unless the Insured Person requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the Hospital or person rendering such services, but it is not required that the service be rendered by a particular Hospital or person.
6. Physical Examination and Autopsy: The Underwriter at its own expenses shall have the right and opportunity to examine the person of any individual whose Injury or Illness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.
7. Legal Actions: No actions at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with requirements of this Policy. No such action shall be brought after expiration of three (3) years after that time written Proof of Loss is required to be furnished.
8. Excess Provision: Even if you have other insurance, the Plan may cover unpaid balances and Deductibles, and pay those eligible medical expenses not covered by other insurance. Benefits will be paid on the unpaid balances after your other insurance has paid. No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible insurance or under an automobile insurance policy. However, this Excess Provision will not be applied to the first $100 of medical expenses incurred.
   Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed as a result of the Insured's failure to comply with policy provisions or requirements. *Important: The Excess Provisions has no practical application if you don't have other medical insurance or if your other insurance does not cover the loss.*
9. Any initial inquiry or complaint should be addressed to the Administrator, as defined herein. If the Insured Person is not satisfied with the manner in which an inquiry or complaint has been managed by the Administrator, the Insured Person may request in writing to the Complaints & Advisory Department at Lloyd's to review the case without prejudice to your rights in law.

   Complaints
   Fidentia House
   Walter Burke Way
   Chatham Maritime
   Chatham
   Kent
   ME4 4RN
   Email: complaints@lloyds.com
   Tel: +44 (0)20 7327 5693

Subrogation

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

Pre-Notification and Network Information

Many facilities inside the U.S. are not familiar with travel medical insurance and this creates unnecessary problems for insureds. Seven Corners Assist must be contacted, and Seven Corners' provider network must be utilized for treatment received in the United States. When contacted properly, Seven Corners Assist is able to notify the network provider of benefits, coverage, and conditions in advance of the insured's arrival. While utilizing the network does not guarantee benefits or that the treating facility will bill Seven Corners directly, it saves the insured from many administrative hassles and places the facility in contact with the Seven Corners claims department.

Seven Corners does not have network facilities outside the United States. Outside of the United States, the insured must pre-notify Seven Corners Assist for any hospital admissions or any inpatient / outpatient surgeries.

Contact information for Seven Corners Assist is below and on the back of your ID Card. A listing of network providers can be found at www.sevencorners.com/help/find-a-doctor on the web. Following these procedures are very important; failure to do so will result in a 20% reduction of eligible benefits.

How to Obtain Travel Assistance

To receive assistance worldwide, call Seven Corners Assist at the numbers below and provide them with your ID Number.
For Emergency Medical Evacuation or Assistance Services, call:
if in the United States, Canada, and the Caribbean: 1-800-690-6295,
or if outside the United States, Canada, or the Caribbean: 1-317-818-2808 (collect)

Claims Services

Important Note: Claim forms and receipts for medical expenses must be sent to Seven Corners quickly. Claim submissions must be made within ninety (90) after the Date of Service. Should they be received after ninety (90) days, they may be considered ineligible.
To report claims or verify eligibility, send the original bills and claim forms to Seven Corners, Inc., or call or fax to the numbers below. Be certain to include your ID# shown on the ID Card with all correspondences:

Seven Corners, Inc.
303 Congressional Blvd; Carmel, IN 46032
800-335-0477 or 317-575-2256 FAX 317-575-2659 email: info@sevencorners.com www.Seven Corners.com

Insurance Underwriter

This Insurance, under Policy **ATR19-190623-01LS**, is underwritten by Certain Underwriters at Lloyds, London, rated A "Excellent" by AM Best.

Appendix A - COORDINATION OF BENEFITS AND SERVICES

Purpose of This Provision

An Insured Person(s) may be covered for health benefits or services by more than one plan. If he/she is, this provision allows the Company to coordinate what the Company pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the primary plan and which is the secondary plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Insured Person(s) is covered.

DEFINITIONS

The words shown below have special meanings when used in this provision. Please read these definitions carefully.

Allowable Expense: The charge for any health care service, supply, or other item of expense for which the Insured Person(s) is liable when the health care service, supply, or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this Certificate is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

The Company will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and Appropriate.

When this Certificate is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, the Company will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Claim Determination Period: A Calendar Year, or portion of a Calendar Year, during which an Insured Person(s) is covered by this Certificate and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts that exceed $150 per day;
e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:

a) Individual or family insurance contracts or subscriber contracts;
b) Individual or family coverage through a health maintenance organization or under any other repayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the Insured Person(s) except when coverage is being continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts of $150 per day or less;
e) School accident type coverage;
f) A State plan under Medicaid.

Primary Plan: A Plan whose benefits for an Insured Person(s)'s health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "a" or "b" below exists:

a) The Plan has no order of benefit determination rules or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
b) All Plans which cover the Insured Person(s) use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Reasonable and Customary: An amount that is not more than the usual or customary charge for the service or supply as determined by the Company, based on a standard which is most often charged for a given service by a Provider within the same geographic area.

Secondary Plan: A Plan which is not a Primary Plan. If an Insured Person(s) is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple secondary plans are paid 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 this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN

The Company considers each plan separately when coordinating payments.

The primary plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the primary plan.

A secondary plan takes into consideration the benefits provided by a primary plan when, according to the rules set forth below, the plan is the secondary plan. If there is more than one secondary plan, the order of benefit determination rules determine the order among the secondary plans. The secondary plan(s) will pay up to the remaining unpaid allowable expenses, but no secondary plan will pay more than it would have paid if it had been the primary plan. The method the secondary plan uses to determine the amount to pay is set forth below in the **Procedures to be Followed by the Secondary Plan to Calculate Benefits** section of this provision.

The secondary plan shall not reduce Allowable Expense for medically necessary and appropriate services and supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the Insured Person(s) as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the Insured Person(s) as a Dependent. The coverage as an employee, member, subscriber or retiree is the primary plan.

The benefits of the Plan that covers the Insured Person(s) as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the Insured Person(s) as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the Insured Person(s) as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the Insured Person(s) under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

a) The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
b) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the parent for a shorter period of time.
c) Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parents was born.
d) If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

a) The benefits of the Plan of the parent with custody of the child shall be determined first.
b) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
c) The benefits of the Plan of the parent without custody shall be determined last.
d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the primary plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:

a) The basis on which the primary plan and the secondary plan pay benefits; and
b) Whether the provider who provides or arranges the services and supplies is in the network of either the primary plan or the secondary plan.

Benefits may be based on the Usual, Reasonable and Customary Charge (U&C), or some similar term. This means that the provider bills a charge and the Insured person(s) may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a Usual, Reasonable and Customary Charge is called a "U&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule or some similar term. This means that although a provider, called a network provider, bills a charge, the Insured person(s) may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Insured person(s) uses the services of a non-network provider, the plan will be treated as a U&C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a capitation. This means that the health maintenance organization (HMO) pays the provider a fixed amount per Insured Person(s). The Insured Person(s) is liable only for the applicable deductible, coinsurance, or copayment. If the Insured person(s) uses the services of a non-network provider, the HMO will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies, and "HMO" refers to a health maintenance organization plan.

Primary Plan is U&C Plan and Secondary Plan is U&C Plan

The secondary plan shall pay the lesser of:

a) The difference between the amount of the billed charges and the amount paid by the primary plan; or

b) The amount the secondary plan would have paid if it had been the primary plan.

When the benefits of the secondary plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in both the primary plan and the secondary plan, the Allowable Expense shall be the fee schedule of the primary plan. The secondary plan shall pay the lesser of:

a) The amount of any deductible, coinsurance or copayment required by the primary plan; or

b) The amount the secondary plan would have paid if it had been the primary plan.

The total amount the provider receives from the primary plan, the secondary plan and the Insured Person(s) shall not exceed the fee schedule of the primary plan. In no event shall the Insured Person(s) be responsible for any payment in excess of the copayment, coinsurance or deductible of the secondary plan.

Primary Plan is U&C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in the secondary plan, the secondary plan shall pay the lesser of:

a) The difference between the amount of the billed charges for the Allowable Charges and the amount paid by the primary plan; or

b) The amount the secondary plan would have paid if it had been the primary plan.

The Insured Person(s) shall only be liable for the copayment, deductible, or coinsurance under the secondary plan if the Insured Person(s) has no liability for copayment, deductible or coinsurance under the primary plan and the total payments by both the primary and secondary plans are less than the provider's billed charges. In no event shall the Insured Person(s) be responsible for any payment in excess of the copayment, coinsurance or deductible of the secondary plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is U&C Plan

If the provider is a network provider in the primary plan, the Allowable Expense considered by the secondary plan shall be the fee schedule of the primary plan. The secondary plan shall pay the lesser of:

a) The amount of any deductible, coinsurance or copayment required by the primary plan; or

b) The amount the secondary plan would have paid if it had been the primary plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is U&C Plan or Fee Schedule Plan

If the primary plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Insured Person(s) receives from a non-network provider is not considered as urgent care or emergency care, the secondary plan shall pay benefits as if it were the primary plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or U&C Plan

If the Insured Person(s) receives services or supplies from a provider who is in the network of both the primary plan and the secondary plan, the secondary plan shall pay the lesser of:

a) The amount of any deductible, coinsurance or copayment required by the primary plan; or

b) The amount the secondary plan would have paid if it had been the primary plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or U&C Plan and Secondary Plan is Capitation Plan

If the Insured Person(s) receives services or supplies from a provider who is in the network of the secondary plan, the secondary plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the primary plan. The Insured Person(s) shall not be liable to pay any deductible, coinsurance or copayments of either the primary plan or the secondary plan.

Primary Plan is an HMO and Secondary Plan is an HMO

If the primary plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Insured Person(s) receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the secondary plan, the secondary plan shall pay benefits as if it were the primary plan.

SEVERABILITY OF INTEREST CLAUSE

This Policy shall operate in all respects as if a separate Policy had been issued to each party insured hereunder, except that in no event shall the total liability of the Insurers in respect of all parties insured hereunder exceed the Limit of Indemnity stated in this Policy. - **LSW1001**

LLOYD'S PRIVACY POLICY STATEMENT

UNDERWRITERS AT LLOYD'S, LONDON

The Certain Underwriters at Lloyd's, London want You to know how we protect the confidentiality of Your non-public personal information. We want You to know how and why we use and disclose the information that we have about You. The following describes our policies and practices for securing the privacy of our current and former customers.

INFORMATION WE COLLECT

The non-public personal information that we collect about You includes, but is not limited to:
Information contained in applications or other forms that You submit to us, such as name, address, and social security number
Information about Your transactions with our affiliates or other third-parties, such as balances and payment history
c) Information we receive from a consumer-reporting agency, such as credit-worthiness or credit history

INFORMATION WE DISCLOSE

We disclose the information that we have when it is necessary to provide our products and services. We may also disclose information when the law requires or permits us to do so,

CONFIDENTIALITY AND SECURITY

Only our employees and others who need the information to service Your account have access to Your personal information. We have measures in place to secure our paper files and computer systems.

RIGHT TO ACCESS OR CORRECT YOUR PERSONAL INFORMATION

You have a right to request access to or correction of Your personal information that is in our possession.

CONTACTING US

If You have any questions about this privacy notice or would like to learn more about how we protect Your privacy, please contact the agent or broker who handled this insurance. We can provide a more detailed statement of our privacy practices upon request. - **LSW1135b**

LLOYD'S

One Lime Street London EC3M 7HA