

WanderSM Frequent Traveler Program Summary

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

Distributed by:
ALL ABOARD BENEFITS
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1-800-462-2322

Quick Contacts

Hospital and Doctor Network in the U.S. - To locate a network facility in the United States, search online at www.sevencorners.com/ppo or contact Seven Corners Assist at 800-690-6295. Advise Seven Corners Assist once you have established an appointment. Use of the network does not guarantee benefits. Please see Pre-Notification / Referral section for additional details and requirements.

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.

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 have been paid to the Administrator.

Note: All coverage and benefit amounts herein are in United States Dollars.

PART I - INDIVIDUAL INSURANCE PROVISIONS

Eligibility

WanderSM Frequent Traveler provides coverage as outlined in this brochure for individuals and families (including unmarried dependent children over 14 days and under 19 years of age) while traveling outside of their Home Country. Home Country is defined as - The country where an Insured Person(s) has his/her true, fixed and permanent home and principal establishment. **In order to be considered eligible under WanderSM Frequent Traveler, each insured person must have primary health insurance coverage.**

Effective Date of Individual Insurance

Your coverage will begin on the latest of the following: 1) The date and time the Application and full plan cost is received and accepted by Seven Corners; or 2) The date requested on the Application.

Termination Date of Individual Insurance

Individual coverage will end on the earlier of the following: 1) 12 months after the effective date; or 2) The date shown on the ID Card, for which plan cost has been paid; 3) The date you are no longer eligible under this plan.; 4) The 30th day of any one trip.

Follow Me Home Coverage

Follow Me Home Coverage: This plan shall pay for Covered Expenses incurred in your Home Country up to **\$5,000** for conditions that are first diagnosed and treated outside Your Home Country (Does not apply for Emergency Medical Evacuation or Repatriation).

Refund of Premium

Seven Corners realizes that there is uncertainty in international travel. Refund of total plan cost will only be considered if written request is received by Seven Corners prior to the Effective Date of Coverage. If written request is received after the Effective Date of coverage, the unused portion of the plan cost may be refunded minus a cancellation fee, provided no claim has been submitted to Seven Corners for reimbursement.

PART II - DESCRIPTION OF BENEFITS ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

The Company shall pay an indemnity determined from the Table if an Insured Person sustains a Loss stated therein resulting from Injury and subject to the limitations contained in PART IV - EXCLUSIONS, provided that: (a) such Loss occurs within 365 days after the date of Accident causing such Loss; and (b) the indemnity payable for any such Loss shall be the Principal Sum stated on the ID Card, as applicable to such Insured Person and this Insurance; and (c) if more than one Loss stated in said Table of Losses is sustained as the result of one Accident, only one of the amounts, the largest, shall be payable.

<u>For Loss of:</u>	<u>Insured or Spouse</u>	<u>Each Child</u>	
Loss of Life	Principal Sum	\$5,000	
Loss of two Members	Principal Sum	\$5,000	
Loss of one Member	50% of Principal Sum	\$2,500	
Quadriplegia	Principal Sum	\$5,000	(total paralysis of both upper and lower limbs)
Paraplegia	75% of the Principal Sum	\$3,750	(total paralysis of both lower limbs)
Hemiplegia	50% the Principal Sum	\$2,500	(total paralysis of both upper & lower limbs of one side of the body)
Uniplegia	25% of the Principal Sum	\$1,250	(total paralysis of one limb)

The term "Loss", in reference to quadriplegia, paraplegia, hemiplegia and uniplegia, shall mean the complete and irreversible paralysis of such limbs and with regard to hands and feet, actual severance through or above the wrist or ankle joints, and with regard to eyes, entire irrecoverable Loss of sight. The term "Principal Sum" as used herein shall mean the amount stated on the ID Card. "Member" means hand, foot or eye. Only one amount, the largest to which you are entitled is payable for all losses resulting from one accident.

Common Carrier Benefit

Benefits will be paid to you as per the schedule of benefits if you sustain an Accidental Death. Death must occur during the period of coverage while the Insured Person is riding as a passenger (but not a pilot, operator or member of the crew) in or on a Common Carrier.

MEDICAL EXPENSE BENEFITS

If the Insured Person is traveling inside the United States and Canada: When a covered Injury or Illness is incurred by the Insured Person, the Company will pay 90% of the first \$5,000 of Reasonable and Customary medical charges for Covered Expenses, excess of the Policy Period Deductible as stated on the ID Card. Thereafter, the Company will pay 100% of Reasonable and Customary medical charges for Covered Expenses up to the medical maximum as stated on the ID Card.

If the Insured Person is traveling outside the United States and Canada: the Company will pay 100% of Reasonable and Customary medical charges for Covered Expenses, excess of the Policy Period Deductible as stated on the ID Card, up to the medical maximum as stated on the ID Card. In no event shall the Company's maximum liability exceed the medical maximum as stated on the ID Card. The Deductible and Coinsurance amount consists of Covered Expenses which would otherwise be payable under this Policy. These expenses must be borne by each Insured Person. A maximum of 3 Policy Period deductibles per family under the same application will apply.

Only such expenses, incurred as the result of and within 180 days from a Disablement, which are specifically enumerated in the following list of charges, and which are not excluded in PART IV - EXCLUSIONS, shall be considered as Covered Expenses:

1. Charges made by a Hospital for room and board, floor nursing and other services inclusive of charges for professional service and (with the exception of personal services of a non-medical nature); charges made for an operating room.

2. Charges made for Intensive Care or Coronary Care charges and nursing services.
3. Charges made for diagnosis, treatment and Surgery by a Physician; charges made for the cost and administration of anesthetics.
4. Charges made for Outpatient treatment, same as any other treatment covered on an Inpatient basis. This includes ambulatory Surgical centers, Physicians' Outpatient visits/examinations, clinic care, and Surgical opinion consultations.
5. Charges for medication, x-ray services, laboratory tests and services, the use of radium and radioactive isotopes, oxygen, blood transfusions, iron lungs, and medical treatment; dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.
6. Charges for physiotherapy, if recommended by a Physician for the treatment of a specific Disablement and administered by a licensed physiotherapist.
7. Ground ambulance (*within the metropolitan area, up to a \$ 5,000 maximum*) to and from the nearest Hospital with facilities for required treatment. If the Insured Person is in a rural area, then licensed ground ambulance transportation to the nearest metropolitan area shall be considered a Covered Expense.
8. Hotel room charge, when the Insured Person, otherwise necessarily confined in a Hospital, shall be under the care of a duly qualified Physician in a hotel room due to unavailability of a Hospital room by reason of capacity or distance or to any other circumstances beyond control of the Insured Person.
9. Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items.

The charges enumerated herein shall in no event include any amount of such charges which are in excess of Reasonable and Customary charges. If the charge incurred is in excess of such average charge, such excess amount shall not be recognized as a Covered Expense. All charges shall be deemed to be incurred on the date such services or supplies which give rise to the expense or charge are rendered or obtained.

PreNotification / Referral – Seven Corners Assist must be contacted prior to: (1) any medical treatment being received in the United States; or (2) hospital admissions worldwide; or (3) inpatient or outpatient surgeries worldwide. Additionally, the Company's appointed network provider must be utilized for medical expenses incurred inside the United States (when available – contact Seven Corners Assist with questions). A listing of network facilities can be found at www.sevencorners.com/findproviders on the world wide web. Pre-notification does not guarantee that benefits will be paid. Failure to follow Pre-Notification / Referral will result in a 20% reduction of Eligible Benefits. (For Emergency admissions and situations, Seven Corners Assist must be contacted within 48 hours, or as soon as reasonably possible.)

COMA BENEFIT

Maximum Benefit Amount: \$50,000

If Injury renders an Insured Comatose within 90 days of the date of the accident that caused the Injury, and if the Coma continues for a period of 30 consecutive days, the Company will pay a monthly benefit equal to 1% of the Maximum Amount. No benefit is provided for the first 30 days of the Coma. The benefit is payable monthly as long as the Insured remains Comatose due to that Injury, but ceases on the earliest of: (1) the date the Insured ceases to be Comatose due to that Injury; (2) the date the Insured dies; or (3) the date the total amount of monthly Coma benefits paid for all Injuries caused by the same accident equals the Maximum Amount. The Company will pay benefits calculated at a rate of 1/30th of the monthly benefit for each day for which the Company is liable when the Insured is Comatose for less than a full month. Only one benefit is provided for any one month of Coma, regardless of the number of Injuries causing the Coma.

The Company reserves the right, at the end of the first 30 consecutive days of Coma and as often as it may reasonably require thereafter, to determine, on the basis of all the facts and circumstances, that the Insured is Comatose, including, but not limited to, requiring an independent medical examination provided at the expense of the Company.

Coma/Comatose - as used in this Rider, means a profound state of unconsciousness from which the Insured cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician.

FELONIOUS ASSAULT BENEFIT

Maximum Benefit Amount: \$10,000

The Company will pay 100% of the Maximum Amount when the Insured suffers one or more losses for which benefits are payable under the Accidental Death Benefit, Accidental Dismemberment Benefit or Coma Benefit provided by the Policy as a result of a Felonious Assault:

1. That is not a moving violation as defined under the applicable government motor vehicle laws; and
2. That is not an act of an Immediate Family Member, another Insured or an individual who resides with the Insured on a permanent basis.

Only one benefit is payable for all losses as a result of the same Felonious Assault.

Felonious Assault - as used, means any willful or unlawful use of force upon the Insured: (1) with the intent to cause bodily Injury to the Insured; and (2) that results in bodily harm to the Insured; and (3) that is a felony or a misdemeanor in the jurisdiction in which it occurs.

HOSPITAL INDEMNITY

Should the Insured Person be hospitalized while traveling outside the United States or Canada, and the hospitalization is considered a Covered Expense, the Company will indemnify the Insured \$150 for each night spent in the hospital up to a maximum of 30 days. This benefit is in addition to any other covered expenses of the program.

EMERGENCY MEDICAL EVACUATION/REPATRIATION

Maximum Benefit Amount: \$300,000

The Company shall pay benefits for Covered Expenses incurred up to **\$300,000**, if any covered Injury or Illness commencing during the Period of Coverage results in the Medically Necessary Emergency Medical Evacuation or Repatriation of the Insured Person. The Emergency Medical Evacuation or Repatriation must be ordered by the Assistance Company in consultation with the Insured Person's local attending Physician.

Emergency Medical Evacuation or Repatriation means: (a) the Insured Person's medical condition warrants immediate transportation from the place where the Insured Person is located 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 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.

REPATRIATION OF REMAINS

Maximum Benefit Amount: \$50,000

The Company will pay the reasonable Covered Expenses incurred up to **\$50,000** to return the Insured Person's remains to his/her then Home Country, if he or she dies. Covered Expenses include, but are not limited to, cremation, expenses for embalming, a minimally necessary container appropriate for transportation, shipping costs, and the necessary government authorizations.

POLITICAL EVACUATION AND REPATRIATION OF REMAINS

Maximum Benefit Amount: \$50,000

If due to political or military events in a host country, a formal recommendation from the appropriate authorities is issued for the Insured to leave the host country or the Insured is expelled or declared persona non-grata by the host country, all reasonable expenses incurred for transportation to the nearest place of safety or for repatriation to the Insured's home country or country of residence are covered up to a maximum of **\$50,000**. Evacuation must occur within 10 days of any such event. Coverage will apply to the most appropriate and economical means consistent under the circumstances with your health & safety. Evacuation costs will be paid once per Insured per occurrence. In the event this benefit is needed, arrangements must be made by the assistance services provider.

For **Political Evacuation and Repatriation**, this insurance does not cover: 1) Losses recoverable under any other insurance or through an employer; 2) Losses arising from or attributable to a) dishonest or criminal acts committed or attempted by the Insured, b) alleged violation of the laws of the host country, unless the company determines such allegations to be fraudulent, or c) failure to maintain required documents or visas; 3) Losses attributable to a) debt, insolvency, commercial failure, or the repossession of any property, b) Insured's non-compliance with a contract or license or c) implementation of illegally contributed exchange rates; 4) Losses due to liability assumed by the Insured under any contract.

EMERGENCY MEDICAL REUNION

Maximum Benefit Amount: \$50,000

When Emergency Medical Evacuation or Repatriation occurs, the Company will arrange and pay, up to **\$50,000**, for round trip economy-class transportation for one individual selected by the Insured Person, from the Insured Person's Home Country to the location where the Insured Person is hospitalized and return to the Home Country. Emergency Medical Reunion must be recommended by the attending Physician. The benefits payable will include: (1) The cost of a round trip economy air fare; (2) Reasonable travel and accommodation expenses (not to exceed **\$200** per day) incurred in relation to the maximum of **\$50,000**. (3) The period of Emergency Medical Reunion is not to exceed 10 days, including travel.

RETURN OF MINOR CHILD(REN)

Maximum Benefit Amount: \$50,000

Should the Insured Person be traveling alone with a Minor Child(ren) and is hospitalized because of a covered Illness or Injury and the Minor Child(ren), under age 19, is left unattended, the Company will arrange and pay, up to **\$50,000**, for one way economy fares to their Home Country. These arrangements will be made at no cost to the Insured Person. Meals and lodging are the responsibility of the Insured Person. If an attendant/escort is necessary to insure the safety and welfare of Minor Child(ren), the Company will arrange and pay for these services to the limit stated in the Schedule of Benefits.

INTERRUPTION OF TRIP

Maximum Benefit Amount: \$5,000

If the Insured is unable to continue the Trip due to the death of a parent, spouse, sibling or child; or due to serious damage to the Insured's principal residence from fire, flood or similar natural disaster (tornado, earthquake, hurricane, etc.), the program will reimburse (up to **\$5,000**), the Insured for the cost of economy travel, less the value of applied credit from an unused return travel ticket, to return home to their area of principal residence.

LOSS OF CHECKED LUGGAGE

Maximum Benefit Amount: \$250

If the Insured's checked luggage is permanently lost by the airline, the program will reimburse the Insured for the replacement of clothing and personal hygiene items lost to a maximum per article limit of **\$50**. This benefit is secondary to any other (including airline) coverage available. The Insured must furnish proof to the Company that full reimbursement has been obtained from the airline. This policy will reimburse the Insured up to a maximum benefit of **\$250** under this provision.

DENTAL - EMERGENCY ONLY

Maximum Benefit Amount: \$500

Emergency Dental treatment necessary to resolve acute, spontaneous and unexpected inception of pain to sound natural teeth (up to a maximum of **\$100**) or Dental treatment necessary to restore or replace sound natural teeth lost or damaged in an Accident which is covered under the program (up to a maximum of **\$500**). The Deductible and Coinsurance amounts apply to the dental benefit.

NOTE: In the event of an Emergency Medical Evacuation/Repatriation, Return of Mortal Remains, Emergency Medical Reunion, Return of Minor Child(ren), or Interruption of Trip benefit is needed, arrangements must be made by the Assistance Company. **Failure to utilize the Assistance Company (Seven Corners Assist) for these benefits will void any payment by the Company.** Complete details about required notification of the Assistance Company are listed below.

ASSISTANCE SERVICES

Pre-Trip Assistance - Telephone information about passports, visas; Telephone information about health hazards in remote areas; Telephone information about inoculations; Help in arranging special medical treatment facilities needed while traveling.

Medical Assistance While Traveling - 24-Hour telephone contact for travel medical emergencies, with assistance in locating medical care; Arranging telephone conferences between your attending and home physicians; Arranging second medical opinions in hospital cases; Relaying emergency messages to family and employer during medical emergencies; Guarantee or payment of medical bills using your available financial resources; 24-hour ticketing service to arrange family visits; Arranging Emergency Medical Evacuation from medically underserved areas; Arranging evacuation for catastrophic claims; Arranging medical transportation home after treatment; Arranging escorts and transportation for unaccompanied children; Arranging transfer of medical records; Arranging Repatriation of Remains for deceased travelers; Notify your health insurer of a claim.

General Travel Assistance - 24 hour telephone contact for baggage and other travel problems; Advice on handling losses and delays; Follow-up contact with airlines regarding baggage; Help with lost passports, ticket and documents; Guarantee or payment of emergency expenses using your available financial resources; Arranging shipments of forgotten, lost or stolen items; Relaying emergency messages.

ID Theft Restoration Service - 24/7 toll-free telephone access to highly trained identity theft specialists; Theft Recovery Kit to help determine if identity theft has occurred and provide guidance in restoring good name and credit; Assignment of a personal case manager who will do most of the identity recovery and follow-up work, if identity theft has occurred; Notify the three major credit bureaus, and the Eligible Person's affected creditors, financial institutions, and utility providers of the identity fraud (US Only); Provide assistance with filing a police report; Research and investigate potential damage to Eligible Person's identity.

Concierge Services - Restaurant referrals and reservations; Event Ticketing; Ground transportation coordination; Golf tee time reservations and referrals; Wireless device assistance; Latest worldwide weather and ski reports; Floral Services - Coordination of flower delivery for birthdays, anniversaries, holidays and other special occasions; Local activity recommendations.

PART III - DEFINITIONS

The term "Accident" or "Accidental" shall mean an event, independent of Illness or self inflicted means, which is the direct cause of bodily Injury to an Insured Person.

The term "Airworthiness Certificate" shall mean the "Standard" Airworthiness Certificate issued by the Federal Aviation Agency of the United States or its foreign equivalent issued by the government authority having jurisdiction over civil aviation in the country of its registry.

The term "Company" shall mean The Insurance Company of the State of Pennsylvania.

The term "Coinsurance" shall mean the percentage amount of eligible Covered Expenses, after the Deductible, which are the responsibilities of the Insured Person and must be paid by the Insured Person. The Coinsurance amount is stated in Section II, Schedule of Benefits, under each stated benefit.

The term "Common Carrier" shall mean any public air conveyance operating under a valid license providing for the transportation of passengers for hire.

The term "Covered Expense" shall mean "Eligible Benefit".

The term "Deductible" shall mean the amount of eligible Covered Expenses which are the responsibility of each Insured Person and must be paid by each Insured Person before benefits under the Policy are payable by the Company.

The term "Disablement" as used with respect to medical expenses shall mean an Illness or an Accidental bodily Injury necessitating medical treatment by a Physician as defined in this Policy.

The term "Eligible Benefit(s)" shall mean benefits payable by the Company to reimburse expenses which are for Medically Necessary services, supplies, care, or treatment; due to Illness or Injury; prescribed, performed or ordered by a Physician; Reasonable and Customary charges; incurred while insured under this program and which do not exceed the maximum benefit.

The term "Emergency" shall mean a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if medical attention is not provided within 24 hours.

The term "Experimental / Investigational" means all services or supplies associated with: 1) treatment or diagnostic evaluation which is not generally and widely accepted in the practice of medicine in the United States of America or which does not have evidence of effectiveness documented in peer reviewed articles in medical journals published in the United States. For the treatment or diagnostic evaluation to be considered effective such articles should indicate that it is more effective than others available; or if less effective than other available

treatments or diagnostic evaluations, is safer or less costly; 2) A drug which does not have FDA marketing approval; 3) A medical device which does not have FDA marketing approval; or has FDA approval under 21 CFR 807.81, but does not have evidence of effectiveness for the proposed use documented in peer reviewed articles in medical journals published in the United States. For the device to be considered effective, such articles should indicate that it is more effective than other available devices for the proposed use; or if less effective than other available devices, or is safer or less costly. The company will make the final determination as to whether a service or supply is Experimental/Investigational.

The term "Hospital" as used in this Policy shall mean except as may otherwise be provided, a Hospital (other than an institution for the aged, chronically ill or convalescent, resting or nursing homes) operated pursuant to law for the care and treatment of sick or Injured persons with organized facilities for diagnosis and Surgery and having 24-hour nursing service and medical supervision.

The term "Home Country" shall mean the country where an Insured Person has his or her true, fixed and permanent home and principal establishment.

The term "Host Country" shall mean any country other than the country where an Insured Person has his or her true, fixed and permanent home and principal establishment.

The term "Illness" wherever used in this Policy shall mean sickness or disease of any kind.

The term "Injury" wherever used in this Policy shall mean bodily Injury caused solely and directly by violent, Accidental, external, and visible means occurring while this Policy is in force and resulting directly and independently of all other causes in Disablement covered by this Policy.

The term "Insured" or "Insured Person" shall mean a person eligible for benefits under the Policy who has applied for coverage and is named on the application and for whom the company has accepted premium.

The term "Intensive Care" shall mean a cardiac care unit or other unit or area of a Hospital which meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

The term "Loss" in reference to quadriplegia, paraplegia, hemiplegia, and uniplegia, shall mean the complete and irreversible paralysis of such limbs and with regard to hands and feet, actual severance through and above the wrist or ankle joints, and with regard to eyes, entire irrecoverable Loss of sight.

The term "Medically Necessary" shall mean services and supplies received while insured that are determined by the Company to be: (1) appropriate and necessary for the symptoms, diagnosis, or direct care and treatment of the Insured Person's medical conditions; (2) within the standards the organized medical community deems good medical practice for the Insured Person's condition; (3) not primarily for the convenience of the Insured Person, the Insured Person's Physician or another Service Provider or person; (4) not Experimental/Investigational or unproven, as recognized by the organized medical community, or which are used for any type of research program or protocol; and (5) not excessive in scope, duration, or intensity to provide safe and adequate, and appropriate treatment. For Hospital stays, this means that acute care as an Inpatient is necessary due to the kinds of services the Insured Person is receiving or the severity of the Insured Person's condition, in that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The fact that any particular Physician may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment Medically Necessary or make the charge of a Covered Expense under this Policy.

The term "Mental Illness" shall mean any condition or disease listed in the most recent edition of the International Classification of Diseases as a mental disorder, which clinically significant behavioral or psychological disorder marked by a pronounced deviation from a normal healthy state and associated with a present painful symptom or impairment in one or more important areas of functioning. This disease must not be merely an expectable response to a particular stimulus. Mental Illness does not mean learning disabilities, attitudinal disorders or disciplinary problems.

The term "Outpatient" shall mean an Insured Person who receives care in a Hospital or another institution, including; ambulatory surgical center; convalescent/skilled nursing facility; or Physician's office, for an Illness or Injury, but who is confined and is not charged for room and board.

The term "Policy Period" or "Period of Coverage" shall mean the Period of Coverage issued by the Company to the Insured Person, typically beginning with the Effective Date and ending with the Termination Date or the date coverage is renewed by the Company.

The term "Physician" as used in this Policy shall mean a doctor of medicine or a doctor of osteopathy licensed to render medical services or perform Surgery in accordance with the laws of the jurisdiction where such professional services are performed, however, such definition will exclude chiropractors and physiotherapists.

The term "Reasonable and Customary" shall mean the maximum amount that the Company determines is Reasonable and Customary for Covered Expenses the Insured Person receives, up to but not to exceed charges actually billed. The Company's determination considers: (1) amounts charged by other Service Providers for the same or similar service in the locality where received, considering the nature and severity of the bodily Injury or Illness in connection with which such services and supplies are received; (2) any usual medical circumstances requiring additional time, skill or experience; and (3) other factors the Company determines are relevant, including but not limited to, a resource based relative value scale. For a Service Provider who has a reimbursement agreement, the Reasonable and Customary charge is equal to the amount that constitutes payment in full under any reimbursement agreement with the Company.

The term "Relative" shall mean spouse, parent, sibling, child, grandparent, grandchild, step-parent, step-child, step-sibling, in-laws (parent, son, daughter, brother and sister), aunt, uncle, niece, nephew, legal guardian, ward, or cousin of the Insured Person.

The term "Service Provider" shall mean a Hospital, convalescent/skilled nursing facility, ambulatory surgical center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, alcohol or drug dependency treatment center, birthing center, physician, dentist, chiropractor, licensed medical practitioner, nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility that the Company approves.

The term "Surgery" shall mean an invasive diagnostic procedure; or the treatment of Illness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.

The term "Traveling Companion" shall mean spouse, parent, sibling, child, grandparent, grandchild, step-parent, step-child, step-sibling, in-laws (parent son, daughter, brother, or sister), aunt, uncle, niece, nephew, legal guardian, ward, or business partner of the Insured Person.

PART IV – EXCLUSIONS

For **Medical benefits**, this Insurance does not cover:

1. Any Injury or Illness which meets the following criteria: (a) condition(s) that would have caused a person to seek medical advice, diagnosis, care or treatment during the 36 months prior to the Effective Date of coverage under this Policy; (b) condition(s) for which manifestation, medical advice, diagnosis, care or treatment was recommended, received, or noticed during the 36 months prior to the Effective Date of coverage under this Policy;
For Insured Persons traveling outside the United States and Canada, the period is 12 months instead of 36 months.
If you are a United States citizen and the United States is your Home Country, this exclusion is waived for the first \$20,000 in eligible medical expenses incurred outside the United States and Canada (*for persons age 65 and over, the amount is \$2,500*). This waiver does not include coverage for known, scheduled, required, or expected medical care, drugs, or treatments existent or necessary prior to the effective date of this program.
If you are a non-United States citizen and suffer a Myocardial Infarction or Stroke and are admitted to a Hospital, this exclusion is waived in order to pay a \$200 per night benefit for each night spent in the Hospital, up to a maximum benefit of \$3,000. The term "Myocardial Infarction" shall mean an acute and emergent onset of any of the conditions and/or diseases described and coded in the International Coding of Diseases version 9 (ICD9), code sequences 410.0 – 410.9 and 414.1 – 419.9. The term "Stroke" shall mean an acute and emergent onset of any of the conditions and/or diseases described and coded in the International Coding of Diseases version 9 (ICD9), code sequence 430-438.9.
2. Charges for treatment which exceed Reasonable and Customary charges; or Charges incurred for Surgeries or treatments which are Investigational, Experimental, or for research purposes; expenses which are nonmedical in nature; expenses for Vocational, Speech, Recreational or Music Therapy;
3. Expenses which were not recommended, approved and certified as Medically Necessary and reasonable by a Physician;
4. Suicide or any attempt thereof, while sane or self destruction or any attempt thereof, while insane; intentionally self-inflicted Injury or Illness; or expenses as a result or in connection with the commission of a felony offense;

5. Any consequence, whether directly or indirectly, approximately or remotely occasioned by, contributed to by, or traceable to, or arising in connection with war, invasion, act of foreign enemy hostilities, warlike operations (*whether war be declared or not*), or civil war;
6. Injury sustained while participating in professional, sponsored and/or organized Amateur or Interscholastic Athletics;
7. Routine physicals, inoculations, or other examinations where there are no objective indications or impairment in normal health;
8. Treatment of the Temporomandibular joint;
9. Services or supplies performed or provided by a Relative of the Insured Person, or anyone who lives with the Insured Person;
10. Treatment and the provision of false teeth or dentures, normal ear tests and the provision of hearing aids, cosmetic or plastic Surgery (including deviated nasal septum), routine dental expenses, eye refractions or eye examinations for the purpose of prescribing corrective lenses for eye glasses or for the fitting thereof, unless caused by Accidental bodily Injury incurred while insured hereunder;
11. Treatment in connection with alcoholism and drug addiction, or use of any drug or narcotic agent; any Mental and Nervous disorders or rest cures; Injury sustained while under the influence of or Disablement due to wholly or partly to the effects of intoxicating liquor or drugs;
12. Congenital abnormalities and conditions arising out of or resulting therefrom;
13. Expenses incurred during a hospital emergency room visit which is not of an emergency nature;
14. Injury sustained while taking part in mountaineering, hang gliding, parachuting, bungee jumping, racing by horse or motor vehicle or motorcycle (*whether as a passenger or driver*), snowmobiling, motorcycle motor scooter riding, scuba diving involving underwater breathing apparatus (unless PADI or NAUI certified), water skiing, snow skiing and snow boarding (**UNLESS HAZARDOUS SPORTS RIDER IS PURCHASED, SEE PROVISION BELOW, AS THIS EXCLUSION IS REPLACED FOR SOME SPORTS**);*
 - Mountaineering shall mean the sport, hobby or profession of walking, hiking, and climbing up mountains either: 1) utilizing harnesses, ropes, crampons or ice axes; or 2) ascending 4500 meters or above.
 - Parachuting shall mean an activity involving the breaking of a free fall from an airplane using a parachute.
15. Treatment paid for or furnished under any other individual, government, or group policy or charges provided at no cost to the Insured Person;
16. Treatment of venereal or sexually transmitted disease;
17. Pregnancy expenses or illness resulting from pregnancy, childbirth, or miscarriage; or for miscarriage resulting from an Accident;
18. Drug, treatment or procedure that either promotes or prevents conception, or prevents childbirth, including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal thereof;
19. Expenses incurred while the Insured Person is in their Home Country (except after approved Emergency Medical Evacuation / Repatriation or if treatment is a follow-up to a covered disablement during coverage, see Follow Me Home Coverage);
20. Expenses incurred for which travel was undertaken to seek medical treatment for a condition; or incurred after the Insured Person's physician has limited or restricted travel.

With regards to Accidental Death and Dismemberment, Emergency Medical Evacuation/Repatriation, Return of Mortal Remains, Emergency Medical Reunion, and Return of Minor Child, this Insurance does not cover:

1. Suicide or attempt thereof by the Insured Person while sane or self destruction or any attempt thereof by the Insured Person while insane;
2. Disease or sickness of any kind; (only applicable to AD&D)
3. Bacterial infections except pyogenic infection which shall occur through an accidental cut or wound; (only applicable to AD&D)
4. Hernia of any kind; (only applicable to AD&D)
5. Injury sustained while the Insured Person is riding as a pilot, student pilot, operator or crew member, in or on, boarding or alighting, from any type of aircraft;
6. Injury sustained while the Insured Person is riding as a passenger in any aircraft (a) not having a current and valid Airworthy Certificate and (b) not piloted by a person who holds a valid and current certificate of competency for piloting such aircraft;
7. Any consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to, or arising in connection with:
 - (a) war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war. (b) mutiny, riot, strike, military or popular uprising insurrection, rebellion, revolution, military or usurped power. (c) any act of any person acting on behalf of or in connection with any organization with activities directed towards the overthrow by force of the Government de jure or de facto or to the influencing of it by terrorism or violence. (d) martial law or state of siege or any events or causes which determine the proclamation or maintenance of martial law or state of siege (hereinafter for the purposes of this Exclusion called the "Occurrences"). Any consequence happening or arising during the existence of abnormal conditions (whether physical or otherwise), whether directly or indirectly, proximately or remotely occasioned by, or contributed to by, traceable to, or arising in connection with, any of the said Occurrences shall be deemed to be consequences for which the Company shall not be liable under this Policy except to the extent that the Insured Person shall prove that such consequence happened independently of the existence of such abnormal conditions;
8. Service in the military, naval or air service of any country;
9. Flying in any aircraft being used for or in connection with acrobatic or stunt flying, racing, endurance tests, rocket-propelled aircraft, crop dusting or seeding or spraying, fire fighting, exploration, pipe or power line inspection, any form of hunting or herding, aerial photography, banner towing or any experimental purpose;
10. Being under the influence of alcohol or having taken drugs or narcotics unless prescribed by a legally qualified physician or surgeon;
11. Injury occasioned or occurring while the Insured Person is committing or attempting to commit a felony or to which a contributing cause was the Insured Person being engaged in an illegal occupation;
12. Riding or driving in any kind of competition;
13. Pregnancy, childbirth, miscarriage or abortion;
14. Covered Expenses incurred after the Insured Person's physician has limited or restricted travel; or Covered Expenses incurred as a result of a change in prescribed treatment during, or within the three months prior to the effective date of coverage.

For Interruption of Trip, this insurance does not cover: (1) war or any act of war, whether declared or not; participation in a felony, riot or insurrection; participation in contests of speed; a Pre-existing Condition existing prior to the Insured's departure from their Home Country that has the likelihood of causing death; the Insured Person or Traveling Companion or Traveling Companion's family making changes to personal plans; having business or contractual obligations; being unable to obtain necessary travel documents (passports, visas, etc.); being detained or having property confiscated by customs authorities; carrier caused delays (including bad weather); prohibition or regulatory by any government; default of yacht charter companies; default of the organization from which the Insured Person purchased their trip arrangements.

For Loss of Checked Luggage, this insurance does not cover: animals; automobiles or automobile equipment; boats; motors; motorcycles; other conveyances or their appurtenances (except bicycles while checked as baggage with a Common Carrier); household furniture; eye glasses or contact lenses; artificial teeth or dental bridges; hearing aids; prosthetic limbs; musical instruments; money or securities; tickets or documents; or sporting equipment if loss or damage results from the use thereof.

Hazardous Sports Coverage (when applicable)

To cover motorcycle/motor scooter riding (*whether as a passenger or driver*), mountaineering (4,500 meter limit), hang gliding, parachuting, bungee jumping, water skiing, snow skiing, snowmobiling, and snow boarding. **Exclusion: Injury sustained while taking part in racing by horse or motor vehicle or motorcycle, scuba diving involving underwater breathing apparatus (unless PADI or NAUI certified);**

Pre Notification / Referral – Seven Corners Assist must be contacted prior to: (1) any medical treatment being received in the United States; or (2) hospital admissions worldwide; or (3) inpatient or outpatient surgeries worldwide. Additionally, the Company's appointed network provider must be utilized for medical expenses incurred inside the United States (when available – contact Seven Corners Assist with questions). A listing of network facilities can be found at www.sevencorners.com/findproviders on the worldwide web. Pre Notification does not guarantee that benefits will be paid. Failure to follow Pre Notification / Referral will result in a 20% reduction of Eligible Benefits. (For Emergency admissions and situations, Seven Corners Assist must be contacted within 48 hours, or as soon as reasonably possible.)

Please be aware that this is not a general health insurance policy, but an interim travel medical program intended for use while away from your Home Country or Country of Residence. WanderSM Frequent Traveler does not guarantee payment to a facility or individual for medical expenses until the Company determines that it is an eligible expense.

PART V - POLICY PROVISIONS

1. Notice of Claim: Written notice of claim must be given to the Company within ninety (90) 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 Company, or to any authorized agent of the Company, with information sufficient to identify the Insured Person shall be deemed notice to the Company.
2. Claim Forms: The Company, 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 Company at its said office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the Company 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 Company 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 Company, 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 Company 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 Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company 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 Company'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 Company 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.

Subrogation

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

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 Corner's 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.

While Seven Corners does not have network facilities outside the United States, the quality of medical attention available is important to us. 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 listed below and on your ID Card. A listing of network providers can be found at www.sevencorners.com/ppo 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, Return of Remains, Emergency Reunion, Return of Minor Child, Assistance Services, call:
If in the United States or Canada: 1-800-690-6295 or if outside the United States or Canada: 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
303 Congressional Blvd; Carmel, IN 46032
800-335-0477 or 317-575-2656 FAX 317-575-2256 email: info@sevencorners.com www.sevencorners.com

Insurance Company

This Insurance, under Policy GLB-9129674, is underwritten by The Insurance Company of the State of Pennsylvania, a member of Chartis Insurance, and is rated A "Excellent" by the A.M. Best Company.