TRAVEL RELAXED... TRAVEL SECURE, YOU'VE GOT

VACATION PROTECT

MEDICAL, EVACUATION PLUS

FOR SERVICE, VISIT OR CALL:
www.travelinsured.com
1-866-684-0218

FOR EMERGENCY ASSISTANCE DURING YOUR TRIP CALL:
1-800-494-9907
1-603-328-1707 (Collect)

Vacation Superstore Network

TRAVEL INSURED INTERNATIONAL®
A CRUM & FORSTER COMPANY
EST. 1822

T-10041 4.15.2017

Vacation Protect
Medical, Evacuation Plus

Note: For residents of AK, CA, CO, IN, KS, MT, NH, NY, OR, TX and WA, this is not Your Certificate of Insurance.

The insurance benefits are underwritten by the United States Fire Insurance Company. Fairmont Specialty and Crum & Forster are registered trademarks of United States Fire Insurance Company. The Crum & Forster group of companies is rated A (Excellent) by AM Best Company 2015. Not all coverage is available in all jurisdictions.
***Travel Assistance non-insurance services are provided by an independent organization and not by United States Fire Insurance Company or Travel Insured International.

YOUR TRAVEL PROTECTION PLAN

Thank you for purchasing a travel protection plan from us!

Please review the following documents carefully, they include:

- Your plan, which explains how your travel protection plan works.
- A letter of confirmation that came with your package of documents, this tells you what coverage you have and the limits. Review this document carefully as it may describe coverage your plan doesn't include.
- Any other information you receive with your package which may include riders or other forms.

Contact us immediately if you think there is a mistake on your letter of confirmation at **1-866-684-0218**. Have your policy # that is on your letter of confirmation available so we can best serve you!

CLAIMS PROCEDURES

To facilitate prompt claims settlement:

TRIP CANCELLATION/TRIP INTERRUPTION:

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

TRIP DELAY: Obtain any specific dated documentation, which provides proof of the reason for delay (airline or Cruise line forms, medical statements, etc).

Submit this documentation along with Your Trip itinerary and all receipts from additional expenses incurred.

MEDICAL EXPENSES: Obtain receipts from the providers of service, etc., stating the amount paid and listing the diagnosis and treatment. (Submit these first to other medical plans. Provide a copy of their final disposition of Your Claim.)

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

Administered by

TRAVEL INSURED INTERNATIONAL®
A CRUM & FORSTER COMPANY

For questions or to report a claim, contact:
Travel Insured International
855 Winding Brook Drive
P.O. Box 6503
Glastonbury, CT 06033
866-684-0218

TABLE OF CONTENTS

WORLDWIDE NON-INSURANCE ASSISTANCE SERVICES

The Travel Assistance feature provides a variety of travel related services.
Services offered include:
• Medical or Legal Referral • Inoculation Information • Hospital Admission Guarantee
• Translation Service • Lost Baggage Retrieval • Passport/Visa Information • Emergency Cash Advance • Bail Bond • Prescription Drug/Eyeglass Replacement

24/7 Worldwide Non-Insurance Assistance Services
Travel Assistance, Medical Emergency, Concierge Service, Business Concierge, Non-Medical Emergency Evacuation and ID Theft Resolution Service
FOR EMERGENCY ASSISTANCE DURING YOUR TRIP CALL:
800-494-9907
(From US/Canada)
OR CALL COLLECT:
603-328-1707
(From all other locations)

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

AVAILABILITY OF SERVICES
You are eligible for information services at any time after You purchase this plan. The Emergency Assistance Services become available when You actually start Your Covered Trip. Emergency Assistance and Informational Services end the earliest of: midnight on the day the program expires; when You reach Your return destination; or when You complete Your Covered Trip.

TRAVEL INSURANCE POLICY

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

TRAVEL PROTECTION INSURANCE
Certificate of Insurance

PLEASE READ THIS DOCUMENT CAREFULLY!
This Certificate of Insurance describes the insurance benefits underwritten by United States Fire Insurance Company, herein referred to as the Company and also referred to as We, Us and Our. The insurance benefits vary from program to program. Please refer to the Schedule of Benefits, which provides the Insured, also referred to as You or Your, with specific information about the program You purchased. You should contact the Company immediately if You believe that the Schedule of Benefits is incorrect.

Signed for United States Fire Insurance Company By:

Marc J. Adee
Chairman and CEO

James Kraus
Secretary

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

If You are not satisfied for any reason, You may return Your Certificate to Travel Insured International within 14 days after receipt. Your premium will be refunded, provided You have not already departed on the Trip or filed a claim. When so returned, the coverage under the Certificate is void from the beginning.

Renewal: Coverage under this Certificate is not renewable. If coverage is needed for an additional Trip, a new enrollment form must be completed and correct premium submitted to Us. A new Pre-Existing Condition Exclusion will apply for each additional Trip.

LIMITED BENEFIT COVERAGE
SCHEDULE OF BENEFITS

Listing of Benefits	Maximum Limit
Travel Protection	
Missed Connection	$300 (3 hours)
Travel Delay ($150 per day)	$500 (12 hours)
Medical Protection	
Emergency Accident and Sickness Medical Expense	$25,000
Dental Sublimit	$1,000
Emergency Evacuation/Medically Necessary Repatriation/Repatriation of Remains	$250,000
Baggage Protection	
Baggage/Personal Effects	$1,500
Per Article Limit	$250
Combined Articles Limit	$500
Baggage Delay	$300 (24 hour)

SECTION I - COVERAGES

COVERAGE A
MISSED CONNECTION

If You miss Your cruise or tour departure because Your arrival at Your Trip destination is delayed for 3 or more hours, due to:

a) any delay of a Common Carrier (the delay must be certified by the Common Carrier);
b) documented weather condition preventing You from getting to the point of departure;
c) quarantine, hijacking, Strike, Natural Disaster, terrorism or riot.

We will reimburse You, up to the Maximum Benefit Amount shown in the Schedule of Benefits, for:

a) Your Additional Transportation Cost to join Your Trip; and
b) Your Prepaid expenses for the unused land or water Travel Arrangements; and
c) reasonable accommodation , telephone and meal expenses necessarily incurred by You for which You have proof of purchase and which were not paid for or provided by any other source.

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

COVERAGE B
TRAVEL DELAY

Benefits will be paid up to $150 per day for: 1) the non-refundable, unused portion of the Prepaid expenses for Your Trip as long as the expenses are supported by proof of purchase and are not reimbursable by any other source; and 2) reasonable accommodation, meal , telephone call and local transportation expenses incurred by You, up to the Maximum Benefit Amount shown in the Schedule of Benefits, if You are delayed for 12 hours or more while en route to or from, or during Your Trip, due to:

a) any delay of a Common Carrier (the delay must be certified by the Common Carrier);
b) a traffic accident in which You or Your Traveling Companion are not directly involved (must be substantiated by a police report);
c) lost or stolen passports, travel documents or money(must be substantiated by a police report);
d) quarantine, hijacking, Strike, Natural Disaster, terrorism or riot;
e) a documented weather condition preventing You from getting to the point of departure.

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

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

COVERAGE C
BAGGAGE AND PERSONAL EFFECTS

Benefits will be provided to You, up to the Maximum Benefit Amount shown in the Schedule of Benefits: (a) against all risks of permanent loss, theft or damage to Your Baggage and Personal Effects; (b) subject to all General Exclusions and the Additional Limitations and Exclusions Specific to Baggage and Personal Effects in the Certificate; and (c) occurring while coverage is in effect. For the purposes of this benefit: “Baggage and Personal Effects” means goods being used by You during Your Trip.

Valuation and Payment of Loss: The lesser of the following amounts will be paid:

1) the Actual Cash Value at the time of loss, theft or damage, except as provided below;
2) the cost to repair or replace the article with material of alike kind and quality; or
3) $250 per article.

We may take all or part of a damaged Baggage as a condition for payment of loss. In the event of a loss to a pair or set of items, We will:

1) repair or replace any part to restore the pair or set to its value before the loss; or
2) pay the difference between the value of the property before and after the loss.

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

A maximum of $100 will be paid for the cost of replacing a passport or visa.

A maximum of $100 will be paid for the cost associated with the unauthorized use or replacement of lost or stolen credit cards, subject to verification that You have complied with all conditions of the credit card company.

Baggage and Personal Effects does not include:

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

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

Additional Limitations and Exclusions Specific to Baggage and Personal Effects:
Benefits are not payable for any loss caused by or resulting from:

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

Additional Provisions applicable to Baggage and Personal Effects and Baggage Delay:
Benefits will not be paid for any expenses which have been reimbursed or for any services which have been provided by the Common Carrier, hotel or Travel Supplier; nor will benefits be paid for loss or damage to property specifically scheduled under any other insurance.

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

a) take all reasonable steps to protect, save or recover the property:
b) promptly notify, in writing, either the police, hotel proprietors, ship lines, airlines, railroad, bus, airport or other station authorities, tour operators or group leaders, or any Common Carrier or bailee who has custody of Your property at the time of loss:
c) produce records needed to verify the claim and its amount ,and permit copies to be made:
d) send proof of loss as soon as reasonably possible after date of loss, providing date, time, and cause of loss, and a complete list of damaged/lost items : and
e) allow the company to examine baggage or personal effects, if requested.

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

COVERAGE G
ACCIDENT AND SICKNESS MEDICAL EXPENSE

Benefits will be paid for the Covered Expense incurred, up to the Maximum Benefit Amount shown in the Schedule of Benefits, as a result of a Covered Accidental Injury or covered Sickness, which first occurs during Your Trip (of a duration of 90 days or less for Sickness). Only Covered Expenses incurred during Your Trip (of a duration of 90 days or less for Sickness) will be reimbursed. Expenses incurred after Your Trip are not covered.

Benefits will include up to $1,000 for expenses incurred during Your Trip for emergency dental treatment. Only expenses for emergency dental treatment to natural teeth incurred during Your Trip will be reimbursed. Expenses incurred after Your Trip are not covered.

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

Advance payment will be made to a Hospital, up to the Maximum Benefit Amount, if needed to secure Your admission to a Hospital, because of a Covered Accidental Injury or covered Sickness. The authorized travel assistance company will coordinate advance payment to the Hospital.

For the purpose of this benefit:
"Covered Expense" means expense incurred only for the following:

1. The medical services, prescription drugs, prosthetics, and therapeutic services and supplies ordered or prescribed by a Legally Qualified Physician as Medically Necessary for treatment;
2. Hospital or ambulatory medical-surgical center services(including expenses for a cruise ship cabin or hotel room, not already included in the cost of the Your Trip, if recommended as a substitute for a hospital room for recovery from a Covered Accidental Injury or covered Sickness);
3. Transportation furnished by a professional ambulance company to and/or from a Hospital.

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

COVERAGE H
EMERGENCY MEDICAL EVACUATION, MEDICAL REPATRIATION AND RETURN OF REMAINS

When You suffer loss of life for any reason or incur a Sickness or Injury during the course of Your Trip, the following benefits are payable, up to the Maximum Benefit Amount shown in the Schedule of Benefits.

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

   If You are traveling alone and will be hospitalized for more than 7 consecutive days and Emergency Evacuation is not imminent, benefits will be paid to transport one person, chosen by You, by Economy Transportation, for a single visit to and from Your bedside.

   If You are in the Hospital for more than 7 consecutive days and Your dependent children who are under 18 years of age and accompanying You on Your Trip are left unattended, Economy Transportation will be paid to return the dependents to their home (with an attendant, if considered necessary by the authorized travel assistance company).

2. **Medical Repatriation**: If the local attending Legally Qualified Physician and the authorized travel assistance company determine that it is Medically Necessary for You to return to Your primary place of residence because of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred will be paid for Your return to Your primary place of residence or to a Hospital or medical facility closest to Your primary place of place of residence capable of providing continued treatment via one of the following methods of transportation, as approved, in writing, by the authorized travel assistance company:
   i) one-way Economy Transportation;
   ii) commercial air upgrade (to Business or First Class), based on Your condition as recommended by the local attending Legally Qualified Physician and verified in writing and considered necessary by the authorized travel assistance company; or
   iii) other covered land or air transportation including, but not limited to, commercial stretcher, medical escort, or the Usual and Customary Charges for air ambulance, provided such transportation has been pre-approved and arranged by the authorized travel assistance company. Transportation must be via the most direct and economical route.

3. **Return of Remains**: In the event of Your death during a Trip, the expense incurred will be paid for minimally necessary casket or air tray, preparation and transportation of Your remains to Your primary place of residence in the United States of America or to the place of burial.

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

If benefits are payable and You have other insurance that may provide benefits for this same loss, We reserve the right to recover from such other insurance. You shall:

a) notify the Company of any other insurance;
b) help the Company exercise the Company's rights in any reasonable way that the Company may request, including the filing and assignment of other insurance benefits;
c) not do anything after the loss to prejudice the Company's rights; and
d) reimburse to the Company, to the extent of any payment the Company has made, for benefits received from such other insurance.

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

SECTION II - DEFINITIONS

"Accident"	means a sudden, unexpected unusual specific event that occurs at an identifiable time and place, and shall also include exposure resulting from a mishap to a conveyance in which You are traveling.
"Actual Cash Value"	means current replacement cost for items of like kind and quality.
"Additional Transportation Cost"	means the actual cost incurred for one-way Economy Transportation by Common Carrier reduced by the value of an unused travel ticket.
"Baggage and Personal Effects"	means luggage, personal possessions and travel documents taken by You on Your Trip.
"Bankruptcy or Default"	means the total cessation of operations due to insolvency, with or without the filing of a bankruptcy petition by an airline, cruise line, tour operator, or other travel provider provided the Bankruptcy or Default occurs more than 14 days following Your Effective Date for the Trip Cancellation Benefits. There is no coverage for the Bankruptcy or Default of any person, organization, agency or firm from whom You purchased Travel Arrangements supplied by others.
"Business Partner"	means an individual who (a) is involved in a legal general partnership with You and (b) is actively involved in the day to day management of Your business.
"Common Carrier"	means any land, sea, or air conveyance operating under a valid license for the transportation of passengers for hire, not including taxicabs or rented, leased or privately owned motor vehicles.
"Complications of Pregnancy"	means conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also include non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible. Complications of Pregnancy does not include false labor, occasional spotting, Physician-prescribed rest during the period of

pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

"Covered Accident" means an Accident that occurs while coverage is in force and results in a loss for which benefits are payable.

"Economy Transportation" means the lowest published available transportation rate for a ticket on a Common Carrier matching the original class of transportation that You purchased for Your Trip.

"Family Member" means any of the following: Your or Your Traveling Companion's legal spouse (or common-law spouse where legal), legal guardian or ward, son or daughter (adopted, foster, step or in-law), brother or sister (includes step or in-law), parent (includes step or in-law), grandparent (includes in-law), grandchild, aunt, uncle, niece or nephew or Domestic Partner.

"Hospital" means (a) a place which is licensed or recognized as a general hospital by the proper authority of the state in which it is located: (b) a place operated for the care and treatment of resident inpatients with a registered graduate nurse (RN) always on duty and with a laboratory and X-ray facility: (c) a place recognized as a general hospital by the Joint Commission on the Accreditation of Hospitals; (d) other than a residence, a place where treatment in a Hyperbaric chamber can be received. Not included is a hospital or institution licensed or used principally: (1) for the treatment or care of drug addicts or alcoholics: or (2) as a clinic continued or extended care facility, skilled nursing facility, convalescent home, rest home, nursing home or home for the aged.

"Inclement Weather" means any weather condition that delays the scheduled arrival or departure of a Common Carrier.

"Injury" or "Injuries" means bodily harm caused by an Accident which: 1) occurs while Your coverage is in effect under the Policy; and 2) requires examination and treatment by a Legally Qualified Physician. The Injury must be the direct cause of loss and must be independent of all other causes and must not be caused by, or result from, Sickness.

"Insured" means a person(s) who is booked to travel on a Trip, and for whom the required premium is paid, also referred to as You and Your.

"Intoxicated" means a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where You are located at the time of an incident.

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

"Maximum Benefit Amount" means the maximum amount payable for coverage provided to You as shown in the Schedule.

"Medically Fit to Travel" means based on assessment a Legally Qualified Physician has advised You, a Traveling Companion, Family Member or Business Partner booked to travel with You in writing that there is no medical condition, illness, Injury or Sickness that would likely interfere with a Trip at the time of purchase of Coverage for a Trip.

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

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

"Natural Disaster" means a flood, hurricane, tornado, earthquake, mudslide, tsunami, avalanche, landslide, volcanic eruption, fire, wildfire or blizzard that is due to natural causes.

"Partial Hospitalization" means an outpatient program specifically designed for the diagnosis or active treatment of a serious mental disorder when there is a reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse or full hospitalization. Partial hospital programs are usually furnished by a hospital as distinct and organized intensive ambulatory treatment service of less than 24-hour daily care.

"Payments or Deposits" means the cash, check, or credit card amounts, or the cash value of Timeshare Points actually paid or used for Your Trip. Certificates, vouchers, discounts, credits, frequent traveler or frequent flyer rewards, miles or points applied (in part or in full) towards the cost of Your Travel Arrangements are not Payments or Deposits as defined herein.

"Penalty" means a fee assessed for canceling a reservation. For airline tickets, the cancellation penalty is usually collected by refunding only a portion of the ticket price. For hotel reservations, the cancellation penalty is charged to the credit card or deposit used to secure the reservations.

"Pre-Existing Condition" means any injury, sickness or condition (including any condition from which death ensues) of the Insured, or Traveling Companion, or Your and/or Traveling Companion's Family Member or Your Business Partner for which within the 180 day period prior to the effective date of Your Trip Cancellation coverage under the policy which (a) manifested itself, became acute or exhibited symptoms which would have caused one to seek diagnosis, care or treatment; (b) required taking prescribed drugs or medicine, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or (c) required medical treatment or treatment was recommended by a Legally Qualified Physician.

"Prepaid" means Payments or Deposits paid by You to a Travel Supplier for Travel Arrangements for Your Trip prior to Your actual or Scheduled Departure Date. Payments or Deposits for shore excursions, theater, concert or event tickets or fees, or sightseeing, if such

	arrangements are made during Your Trip and are to be used prior to the Scheduled Return Date of your Trip, are not considered Prepaid as defined herein.
"Published Penalties"	means any published cancellation penalties levied by Your travel agency or travel supplier that apply to all clients of the travel agency or travel supplier and can be documented at time of Your purchase of Travel Arrangements from Your travel agency.
"Scheduled Departure Date"	means the date on which You are originally scheduled to leave on Your Trip.
"Scheduled Return Date"	means the date on which You are originally scheduled to return to the point of origin or the original final destination of Your Trip.
"Sickness"	means an illness or disease of the body which: 1) requires examination and treatment by a Legally Qualified Physician, and 2) commences while Your coverage is in effect.
"Strike"	means any organized and legally sanctioned labor disagreement resulting in a stoppage of work: (a) as a result of a combined effort of workers which was unannounced and unpublished at the time travel services were purchased; and (b) which interferes with the normal departure and arrival of a Common Carrier.
"Terrorist Incident"	means an act of violence, that is deemed terrorism by the United States Government other than civil disorder or riot (that is not an act of war, declared or undeclared) that results in loss of life or major damage to property, by any person acting alone or in association with other persons on behalf of or in connection with any organization of foreign government which is generally recognized as having the intent to overthrow or influence the control of any other foreign government. The Terrorist Incident must be documented in a Travel Warning issued by the United States' Department of State advising Americans to avoid that certain country.
"Third Party"	means a person or entity other than You or the Company.
"Transportation Expense"	means: (a) the cost of conveyance of You and any medical personnel (if Medically Necessary): and (b) Medically Necessary services or supplies.
"Traveling Accomodations"	means: (a) transportation; (b) accommodations; and (c) other specified services arranged by the Travel Supplier for Your Trip. Air arrangements covered by this definition also include any direct round trip air flights booked by others, to and from Your Scheduled Trip Departure and return cities, provided the dates of travel for the air flights are within 7 total days of Your scheduled Trip dates.
"Traveling Companion"	means a person or persons whose names appear with Yours on the same Travel Arrangements and who, during Your Trip, will accompany You, will share accommodations with You in the same room, cabin, condominium unit, apartment unit or other lodging. A group or tour organizer, sponsor or leader is not a Traveling Companion as defined, unless sharing accommodations in the same room, cabin, condominium unit, apartment unit or other lodging with You.

"Travel Supplier"	means any entity or organization that coordinates or supplies travel services for You.
"Trip"	means a scheduled trip for which coverage for Travel Arrangements is requested and the premium is paid prior to Your actual or Scheduled Departure Date of Your Trip.
"Us", "We", "Our"	means United States Fire Insurance Company.
"Usual and Customary Charges"	means those comparable charges for similar treatment, services and supplies in the geographic area where treatment is performed.

SECTION III. INSURING PROVISIONS

Who Is Eligible For Coverage:
A citizen or resident of the United States of America who is booked to travel on Your Trip, completes the enrollment form and for whom the required premium is paid. Eligibility for purchase will be determined at time of claim. If it is determined that a person or Trip is not eligible for coverage, any claim for benefits will be denied and premium will be refunded.

When Coverage Begins – Coverage Effective Date:
Trip Cancellation: Coverage begins on the date and time at 12:01 a.m. on the day after the date the appropriate premium for this Certificate for Your Trip is received by the company. This is Your "Effective Date" and time for Trip Cancellation.

Travel Delay: Coverage begins after You have traveled 50 miles or more from home en route to join Your Trip. This is Your "Effective Date" and time for Travel Delay.

All Other Coverages: Coverage begins when You depart on the first Travel Arrangement (or alternate travel arrangement if You must use an alternate travel arrangement to reach Your Trip destination) for Your Trip. This is Your "Effective Date" and time for all other coverages, except Trip Cancellation and Travel Delay.

When Coverage Ends – Coverage Termination Date:
Trip Cancellation: Your coverage automatically ends on the earlier of: 1) 72 hours prior to the scheduled departure time on the Scheduled Departure Date of Your Trip cruise tour the date and time You depart on Your Trip cruise tour; or 2) on or before the final payment due date for Your Trip; or 3) the date and time You cancel Your Trip.

All Other Coverages: Your coverage automatically ends on the earlier of: 1) the date Your Trip is completed; 2) the Scheduled Return Date; 3) Your arrival at Your return destination on a round-trip, or the destination on a one-way trip; 4) cancellation of Your Trip covered by the Certificate. Termination of the Certificate will not affect a claim for loss that occurs after premium has been paid.

All coverages under the Certificate will be extended if Your entire Trip is covered by the Certificate and Your return is delayed due to unavoidable circumstances beyond Your control. If coverage is extended for the above reasons, coverage will end on the earlier of the date You reach Your originally scheduled return destination or 7 days after the Scheduled Return Date.

SECTION IV - GENERAL EXCLUSIONS AND LIMITATIONS

Benefits are not payable for any loss due to, arising or resulting from:

1. suicide, attempted suicide or any intentionally self-inflicted injury of You, a Traveling Companion, Family Member or Business Partner booked to travel with You, while sane or insane;
2. an act of declared or undeclared war;
3. participating in maneuvers or training exercises of an armed service, except while participating in weekend or summer training for the reserve forces of the United States, including the National Guard;
4. riding or driving in races, or speed or endurance competitions or events;
5. mountaineering (engaging in the sport of scaling mountains generally requiring the use of picks, ropes, or other special equipment);
6. participating as a member of a team in an organized sporting competition or participating as a professional in a stunt, athletic or sporting event or competition;
7. participating in bodily contact sports, skydiving or parachuting, hang gliding, or bungee cord jumping.
8. piloting or learning to pilot or acting as a member of the crew of any aircraft;
9. being Intoxicated as defined herein, or under the influence of any controlled substance unless as administered or prescribed by a Legally Qualified Physician;
10. the commission of or attempt to commit a felony or being engaged in an illegal occupation;
11. normal childbirth or pregnancy (except Complications of Pregnancy) or voluntarily induced abortion;
12. dental treatment (except as coverage is otherwise specifically provided herein);
13. amounts which exceed the Maximum Benefit Amount for each coverage as shown in the Schedule of Benefits;
14. due to a Pre-Existing Condition, as defined in the Certificate. The Pre-Existing Condition Limitation does not apply to the Emergency Medical Evacuation or Return of Remains coverage;
15. medical treatment during or arising from a Trip undertaken for the purpose or intent of securing medical treatment; a mental or nervous condition, unless hospitalized for that condition while the Certificate is in effect for You;
16. a mental or nervous condition, unless hospitalized for that condition while the Certificate is in effect for You;
17. due to loss or damage (including death or injury) and any associated cost or expense resulting directly from the discharge, explosion or use of any device, weapon or material employing or involving chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act and regardless of any other sequence thereto.

PRE-EXISTING CONDITION EXCLUSION:

The Company will not pay for any expense as a result of any illness, disease, or other condition during the 180 day period immediately prior to the date Your coverage is effective for which You or Your Traveling Companion, Business Partner or Family Member scheduled or booked to travel with You: 1) received or received a recommendation for a test, examination, or medical treatment for a condition which first manifested itself, worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment; or 2) took or received a prescription for drugs or medicine. Item (2) of this Exclusion does not apply to a condition which is

treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the 180 day period before coverage is effective under this Certificate.

Waiver of the Pre-Existing Condition Exclusion

The exclusion for Pre-Existing Condition will be waived provided:

a) Your Payment or Deposit for this plan and enrollment form are received within 14 days of the date Your initial Payment or Deposit for Your Trip is received ;
b) You insure all Prepaid Trip costs that are subject to cancellation penalties or restrictions and also insure within 14 days of the Payment or Deposit for those Travel Arrangements the cost of any subsequent Travel Arrangements (or any other Travel Arrangements not made through Your travel agent) added to Your Trip;
c) You are not disabled from travel at the time Your premium is paid.

MEDICALLY FIT TO TRAVEL EXCLUSION:

The Company will not pay any expense as a result of You having been advised in writing that You, a Traveling Companion, Family Member or Business Partner booked to travel with You are not Medically Fit to Travel, as defined in the Certificate, at the time of purchase of Coverage for a Trip. If Coverage for a Trip is purchased and it is later determined that You, a Traveling Companion, Family Member or Business Partner booked to travel with You were not Medically Fit to Travel, as defined in the Certificate , at the time of purchase of Coverage for a Trip, the Coverage is void and premium paid will be returned.

SECTION V - GENERAL PROVISIONS

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

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

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

Time of Payment of Claims: We, or Our designated representative, will pay the claim after receipt of acceptable proof of loss.

Payment of Claims: Benefits for loss of life will be paid to Your designated beneficiary. If a beneficiary is not otherwise designated by You, benefits for loss of life will be paid to the first of the following surviving preference beneficiaries:

a) Your spouse;
b) Your child or children jointly;
c) Your parents jointly if both are living or the surviving parent if only one survives;
d) Your brothers and sisters jointly; or

e) Your estate

All other Benefits will be paid directly to You, unless otherwise directed. Any accrued benefits unpaid at Your death will be paid to Your estate. If You have assigned Your benefits, We will honor the assignment if a signed copy has been filed with us. We are not responsible for the validity of any assignment.

All or a portion of all benefits provided by the Certificate may, at Our option, be paid directly to the provider of the service(s) to You. All benefits not paid to the provider will be paid to You.
If any benefit is payable to: (a) an Insured who is a minor or otherwise not able to give a valid release; or (b) the Insured's estate, We may pay any amount due under the Certificate to the Insured's beneficiary or any relative whom We find entitled to the payment. Any payment made in good faith shall fully discharge Us to any party to the extent of such payment.

Excess Insurance: The insurance provided by this Certificate shall be in excess of all other valid and collectible Insurance or indemnity. If at the time of the occurrence of any loss there is other valid and collectible insurance or indemnity in place, the Company shall be liable only for the excess of the amount of loss, over the amount of such other insurance or indemnity, and applicable deductible. Recovery of losses from other parties does not result in a refund of premium paid.

Physician Examination and Autopsy: The Company, at the expense of the Company, may have You examined when and as often as is reasonable while the claim is pending. The Company may have an autopsy done (at the expense of the Company) where it is not forbidden by law.

Legal Actions: All policy terms will be interpreted under the laws of the state in which the Policy was issued. No legal action may be brought to recover on the Policy within 60 days after written Proof of Loss has been furnished. No legal action for a claim may be brought against Us after 3 years from the time written Proof of Loss is required to be furnished.

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

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

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

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

STATE ENDORSEMENTS

The Amendatory Endorsements are attached to and made a part of the Policy issued to the Insured. The provisions of the Amendatory Endorsements are effective on the Effective Date and will expire concurrently with the Policy, unless otherwise terminated.

The Policy/Certificate are hereby amended for Arkansas as follows:

ARKANSAS

1. The Legal Actions provision appearing in SECTION V General Provisions is deleted and replaced as follows:
   Legal Actions: All policy terms will be interpreted under the laws of the state in which the policy was issued. Legal action or suit for a claim may be brought against Us within the time allowed by law.
2. The Subrogation provision appearing in SECTION V General Provisions is amended to include this sentence which will appear as follows at the end of the provision: The Company is entitled to recovery only after You have the Insured has been fully compensated for the loss sustained.

If there is a conflict between the Policy/Certificate and this Rider, the terms of this Endorsement will govern.
T210-AE AR

The Certificate is hereby amended for Connecticut Residents as follows:
The following is added to the Face Page of the Certificate:

CONNECTICUT

1. The following Exclusion 4. in SECTION IV GENERAL EXCLUSIONS is deleted and replaced as follows:
2. no indemnity will be paid for loss caused by the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by the Insured's Legally Qualified Physician;
3. Exclusion 19. in SECTION IV GENERAL EXCLUSIONS referencing chemical, biological, radiological or similar agents is deleted in its entirety and will not appear.
4. The Excess Insurance provision in SECTION V GENERAL PROVISIONS is deleted and will not appear.
5. The Subrogation provision in SECTION V GENERAL PROVISIONS is deleted and replaced as follows: Subrogation: If the Company has made a payment for a loss under this coverage, and the person to or for whom payment was made has a right to recover damages from the Third Party responsible for the loss, the Company will be subrogated to that right as permitted by law. You shall help the Company exercise the Company's rights in any reasonable way that the Company may request: nor do anything after the loss to prejudice the Company's rights: and in the event You recover damages from the Third Party responsible for the loss, You will hold the proceeds of the recover for the Company in trust and reimburse the Company to the extent of the Company's previous payment for the loss, as permitted by law.
6. The following is added to SECTION V GENERAL PROVISIONS:
   Required Connecticut Statement regarding termination of Participating Organization or Master Group Policy: In the event of termination of the Participating Organization or the Master Group

Policy, coverage issued under this Certificate for which the required premium payment has been paid prior to that termination date will continue until the end of Your Trip.

7. SECTION VI COORDINATION OF BENEFITS is deleted in its entirety and will not appear.

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Endorsement will govern.
T210-AE CT

DISTRICT OF COLUMBIA

1. The following will appear at the bottom of the Cover Page, directly above the TABLE OF CONTENTS:
   LIMITED BENEFIT COVERAGE
2. SECTION V GENERAL PROVISIONS is amended to include the following provisions:
   Fraud Warning as required for District of Columbia Residents: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.
   Required District of Columbia Statement regarding termination of Participating Organization or Master Group Policy: In the event of termination of the Participating Organization or the Master Group Policy, coverage issued under this Certificate for which the required premium payment has been paid prior to that termination date will continue until the end of Your Trip.

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Endorsement will govern.
T210-AE DC

The Policy/Certificate are hereby amended for Florida Residents as follows:

FLORIDA

The Legal Actions provision appearing in SECTION V General Provisions is deleted and replaced as follows:
Legal Actions: No legal action may be brought to recover on the Policy until 60 days after the Company receives Proof of Loss. No legal action for a claim may be brought against Us more than 5 years after the time required by law for giving Proof of Loss. This 5 year time period is extended from the date Proof of Loss is furnished and the date the claim is denied in whole or in part.
If there is a conflict between the Policy/Certificate and this Rider, the terms of this Endorsement will govern.
T210-AE FL RESIDENTS ONLY

The Policy/Certificate are hereby amended for Georgia Residents as follows:

GEORGIA

The Concealment and Misrepresentation provision appearing in SECTION V General Provisions is deleted and replaced as follows:
Concealment and Misrepresentation: The entire coverage will be cancelled, if before, during or after a loss, any material fact or circumstance relating to this insurance has been concealed or misrepresented.

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Georgia Amendatory Endorsement will govern.

T210-AE-GA

The Certificate is hereby amended for Hawaii Residents as follows:
The following is added to SECTION V GENERAL PROVISIONS as follows:
HAWAII
Representations: All statements made by the Insured are deemed representations and not warranties. No statement made by the Insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the Insured or to the Insured's beneficiary, if any. A misrepresentation, unless it is made with actual intent to deceive or unless it materially affects the acceptance of the risk assumed by the Company, shall not prevent a recovery under the Certificate.

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Endorsement will govern.
T210-AE-HI

The Policy/Certificate are hereby amended for Idaho as follows:
IDAHO
1. The following is added at the bottom of SECTION V General Provisions:
   Contact Information for the Idaho Department of Insurance:
   Idaho Department of Insurance Consumer Affairs
   700 W. State Street, 3rd Floor PO Box 83720
   Boise, ID 83720-0043
   1-800-721-3272 or 208-334-4250 or www.DOI.Idaho.gov

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Endorsement will govern.
T210-AE-ID

The Policy/Certificate are hereby amended for Illinois as follows:
ILLINOIS
A. Item b.(i) under "Other Covered Reasons" in both TRIP CANCELLATION and TRIP INTERRUPTION appearing in SECTION I COVERAGES is deleted and replaced as follows:
   (i) the building structure itself is unstable and there is a risk of collapse;
B. Item 1. in the Injury definition in both TRIP CANCELLATION AND INTERRUPTION DUE TO YOUR INABILITY TO DIVE and LOST DIVING DAYS appearing in SECTION I COVERAGES is deleted and replaced as follows:
   1. is direct and independent of disease or bodily infirmity;
C. Item B. in the Exclusions in TRIP CANCELLATION AND INTERRUPTION DUE TO YOUR INABILITY TO DIVE is deleted and replaced as follows:
   B. The Company will not be liable for claims, under the Coverage Part B, directly arising from any hazardous pursuit or occupation or flying except while flying as a passenger in a fully-licensed multi- engine passenger-carrying aircraft.
D. The last sentence in the definition of "Injury" or "Injuries" appearing in SECTION II DEFINITIONS is deleted and replaced as follows:
   The Injury must be the direct cause of loss and must be independent of disease or bodily infirmity and must not be caused by, or result from, Sickness.
E. The definition of "Complications of Pregnancy" appearing in SECTION II DEFINITIONS is deleted and replaced as follows:

"Complications of Pregnancy" means conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy. These conditions include acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, preeclampsia, missed abortion and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also include non elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

F. Item 1) in the definition of "Pre-Existing Condition" appearing in SECTION II DEFINITIONS is deleted and replaced as follows:
   1) received or received a recommendation for a test, examination, or medical treatment for a condition which manifested itself, worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment;
G. Item 1) in the Pre-Existing Condition Exclusion appearing in SECTION IV General Exclusions is deleted and replaced as follows:
   1) received or received a recommendation for a test, examination, or medical treatment for a condition which manifested itself, worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment;
H. The Time of Payment of Claims provision appearing in SECTION V General Provisions is deleted and replaced as follows:
   Time of Payment of Claims: We, or Our designated representative, will pay the claim within 30 days after receipt of acceptable proof of loss. Failure to pay within such period shall entitle the Insured to interest at the rate of 9% per annum from the 30th day after receipt of acceptable proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid.

T210-AE IL

Illinois Guaranty Notice

Title 50, Chapter I, Subchapter 11, Part 3401 of the Illinois Insurance Code requires all Group Life and Health insurers to provide a summary of the basic provisions of the Illinois Life and Health Insurance Guaranty Association Law.

Any questions concerning this summary should be directed to the Illinois Life and Health Guaranty Association or to the Illinois Insurance Department at the addresses contained in the summary.

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER
The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association 8420 West Bryn Mawr Avenue Chicago, Illinois 60631 (773) 714-8050 ILHIGA@aol.com

Illinois Department of Insurance 320 West Washington Street 4th Floor Springfield, Illinois 62767 (217) 782-4515 http://www.insurance.illinois.gov

SUMMARY OF GENERAL PURPOSES AND CURRENT LIMITATIONS OF COVERAGE
The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") 215 ILCS 5/531.01, et seq.. The following contains a brief summary of the Law's coverages, exclusions, and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:
1) Direct non group life insurance, health insurance, annuity and supplemental contracts;
2) life, health, annuity certificates under direct group policies or contracts;
3) unallocated annuity contracts; and
4) contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.

1) the insurer that issued the policies or contracts domiciled in Illinois; and
2) the states in which the persons reside have associations similar to the Illinois Association; and
3) the persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in that state at the time specified in that state's guaranty association law.

Exclusions from Coverage:
1) The Guaranty Association does not provide coverage for:

A) any policy or portion of a policy for which the individual has assumed the risk;
B) any policy of reinsurance (unless an assumption certificate was issued);
C) interest rate guarantees which exceed certain statutory limitations;
D) any unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of the contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
E) any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery.
F) any policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D) or any regulations issued pursuant thereto;
G) any portion of a policy or contract to the extent that the assessments required by Section 531.09 of this Code with respect to the policy or contract are preempted or otherwise not permitted by federal or State law;
H) any portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or other person under:
    a) a multiple employer welfare arrangement as defined in 29 U.S.C. Section 1144;
    b) a minimum premium group insurance plan;
    c) a stop loss group insurance plan; or
    d) an administrative services only contract.
I) any portion of a policy or contract to the extent that it provides for:
    a) dividends or experience rating credits;
    b) voting rights; or
    c) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service or administration of the policy or contract;
J) any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
K) any contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is to an affiliate of the member insurer;
L) any portion of a policy or contract to the extent that it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have notbeen credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this Code, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this Section, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of the impairment or insolvency, whichever is earlier, and will not be subject to forfeiture; or
M) any stop loss insurance.

2) In addition, persons are not protected by the Guaranty Association if:
   A) the Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
   B) their policy was issued by an organization which is not a member insurer of the Association was not licensed or did not have a certificate of authority to issue the policy or contract in this State.
      d) Limits on Amount of Coverage:
         1) The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty's Association's liability is limited to the lesser of either:
            A) the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or
            B) with respect to any one life, regardless of the number of policies, contracts, or certificates:
               i) in the case of life insurance, $300,000 in death benefits but nor more than $100,000 in net cash surrender or withdrawal values;
               ii) in the case of health insurance:
                  a) $100,000 for coverages not defined as disability insurance or basic hospital, medical, and surgical insurance or major medical insurance or long-term care insurance, including any net cash surrender and net cash withdrawal values;
                  b) $300,000 for disability insurance and $300,000 for long-term care insurance as defined in Section 351 A-1 of this Code; and
                  c) $500,000 for basic hospital medical and surgical insurance and major medical insurance;
               iii) with respect to annuities 100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and $100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is $5,000,000 in benefits per contract holder, regardless of the number of contracts.
                  e) However, in no event is the Guaranty Association liable for more than (1) in aggregate of $300,000 in benefits with respect to any one life except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual or (2) with respect to one owner of multiple non group policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person and whether the persons insured are officers, managers, employees, or other persons, $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

The Policy/Certificate are hereby amended for Louisiana as follows:

LOUISIANA

1. The Time of Payment of Claims provision appearing in SECTION V General Provisions is deleted and replaced as follows:
   Time of Payment of Claims: We, or Our designated representative, will pay the claim within 30 days after receipt of acceptable proof of loss.
2. The Legal Actions provision appearing in SECTION V General Provisions is deleted and replaced as follows:
   Legal Actions: No legal action for a claim can be brought against the Company until 45 days after the Company receives proof of loss. No legal action for a claim can be brought against the Company more than 3 years after the time required for giving proof of loss. This 3-year time period is extended from the date proof of loss is filed and the date the claim is denied in whole or in part.
3. The Concealment and Misrepresentation provision appearing in SECTION V General Provisions is deleted and replaced as follows:
   Concealment and Misrepresentation: The entire coverage will be void, if when applying for coverage, You the Insured made a fraudulent statement or misrepresentation with the intent to deceive. Fraud or misrepresentation with the intent to deceive after coverage is in force is grounds for cancellation and grounds to deny coverage for benefits related to such fraud, concealment, or misrepresentation. Coverage for other benefits will continue until the cancellation is effective.
4. The Subrogation provision appearing in SECTION V General Provisions is deleted and replaced as follows:
   Subrogation: If the Company make any payment under this coverage and the person to or for whom payment is made has a right to recover damaged from another, the Company shall be subrogated to that right. However, the Company's right to recover is subordinate to Your/the Insured's right to be fully compensated.

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Endorsement will govern.
T210-AE LA

The Policy/Certificate are hereby amended for Maryland as follows:

MARYLAND

1. On the Cover Page, the last sentence in the third paragraph indicating "When so returned, the coverage under this Certificate is void from the beginning" is deleted and will not appear.
2. The Concealment and Misrepresentation provision appearing in SECTION V GENERAL PROVISIONS is deleted and replaced as follows:
   Concealment and Misrepresentation: The entire coverage will be cancelled, if before, during or after a loss, any material fact or circumstance relating to this insurance has been concealed or misrepresented.

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Maryland Amendatory Endorsement will govern.
T210-AE MD

The Certificate is hereby amended for Maine Residents as follows:

MAINE

1. The references to $1,000 within the Maximum Benefit Amount/Principal Sum ranges in the SCHEDULE OF BENEFITS for Accidental Death and Dismemberment, 24-Hour (Other than

Air Flight), 24- Hour (Other than Common Carrier), Air Flight Only and Common Carrier Only are deleted and replaced with $2,000.

2. The bottom three Types of Losses in 24-HOUR ACCIDENTAL DEATH AND DISMEMBERMENT are deleted and replaced as follows:
   Loss of thumb and index finger of the same hand 100% of Principal Sum
   Loss of Speech 100% of Principal Sum
   Loss of Hearing One Ear Both Ears One Ear 50% of Principal Sum 100% of Principal Sum
3. The definition of Actual Cash Value appearing in SECTION II DEFINITIONS is deleted and replaced as follows:
   "Actual Cash Value" means the replacement cost of an insured item of property at the time of loss, less the value of Physical Depreciation as to the item damaged. As used in this definition, Physical Depreciation means a value as determined according to standard business practices.
4. The Concealment and Misrepresentation provision in SECTION V GENERAL PROVISIONS is deleted and replaced as follows:
   Concealment and Misrepresentation: The entire coverage will be cancelled, if before, during or after a loss, any material fact or circumstance relating to this insurance has been fraudulent or materially misrepresented. Notice of cancellation of the entire coverage will be delivered to the Insured at the Insured's last known address, and cancellation shall become effective 10 days after receipt by the Insured.

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Endorsement will govern.
T210-AE ME

MINNESOTA

The Certificate is hereby amended for Minnesota Residents as follows:

1. The third paragraph of the Face Page is deleted and replaced as follows:
   Insurance is provided by a Group Policy issued in a state other than Minnesota. Certificates delivered to residents of Minnesota are subject to the terms of the Certificate and this Minnesota Amendatory Endorsement and not the Group Policy.
2. All references to "Confirmation of Benefits" are hereby deleted and will not apply.
3. The following is added to appear as General Exclusion 31. or will appear as the last numbered Exclusion in SECTION IV GENERAL EXCLUSIONS:
   31. Air, water or other pollution, or threat of a pollutant release;
4. The Time of Payment of Claims and Concealment and Misrepresentation provisions in SECTION V GENERAL PROVISIONS are deleted and replaced as follows:
   Time of Payment of Claims: We, or Our designated representative, will pay the claim within five business days after receipt of acceptable proof of loss.
   Concealment and Misrepresentation: The entire coverage will be void, if before, during or after a loss, any material fact or circumstance relating to this insurance was orally misrepresented or misrepresented in writing with intent to deceive and defraud, or the misrepresentation increases the risk of loss.
5. The following is added as the last sentence in the Subrogation provision in SECTION V GENERAL PROVISIONS:
   The Company may not subrogate itself to the rights of an Insured to proceed against another person if that other person is an Insured by the Company for the same loss.

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Endorsement will govern.
T210-AE MN

The Policy/Certificate are hereby amended for Nebraska as follows:

NEBRASKA

A. Item 1. in the definition of Pre-Existing Condition appearing in SECTION II DEFINITIONS is deleted and replaced as follows: 1) received a recommendation for a test, examination, or medical treatment for a condition which first manifested itself, worsened or became acute or exhibited a subjective indication of a disease or a change in condition as perceived by You which would have prompted a reasonable person to seek diagnosis, care or treatment;
B. In Exclusion 4. appearing in SECTION IV GENERAL EXCLUSIONS, the reference to "races" is changed to "organized races".
C. In Exclusion 7. appearing in SECTION IV GENERAL EXCLUSIONS, the reference to "any race" is changed to "any organized race".
D. Item 1. in the PRE-EXISTING CONDITION EXCLUSION provision appearing in SECTION IV GENERAL EXCLUSIONS is deleted and replaced as follows:
    1) received a recommendation for a test, examination, or medical treatment for a condition which first manifested itself, worsened or became acute or exhibited a subjective indication of a disease or a change in condition as perceived by You which would have prompted a reasonable person to seek diagnosis, care or treatment;
E. The Time of Payment of Claims provision appearing in SECTION V GENERAL PROVISIONS is deleted and replaced as follows:
    Time of Payment of Claims: We, or Our designated representative, will pay the claim immediately (or within 30 days) after receipt of acceptable proof of loss.

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Endorsement will govern.
T210-AE NE

The Policy is hereby amended for Nevada as follows:

1. SECTION V TERMINATION OF MASTER POLICY is deleted and replaced as follows:
    NEVADA
    If the Policy has been in effect for less than 70 days, the Policyholder or the Company may terminate the Master Policy by giving 31 days advance written notice to the other party. Termination is without prejudice to any claims that exist on such date.

    If the Policy has been in effect for 70 days or more, the Company may terminate the Master Policy before the expiration of the agreed term for any one of the following grounds:
        (a) failure to pay premium when due;
        (b) conviction of the Insured of a crime arising out of acts increasing the hazard insured against;
        (c) discovery of fraud or material misrepresentation in the obtaining of the Master Policy or in the presentation of a claim thereunder;
        (d) discovery of an act of omission or a violation of any condition of the Master Policy.

If there is a conflict between the Policy and this Endorsement, the terms of this Endorsement will govern.

The Certificate is hereby amended for Ohio as follows:

OHIO

A. The following statement is added to the Face Page of the Certificate:
WARNING: Any person who knowingly, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

B. The Who is Eligible For Coverage provision appearing SECTION III INSURING PROVISIONS is deleted and replaced as follows:
Who Is Eligible For Coverage:
A citizen or resident of the United States of America who is booked for travel on Your Trip, completes the enrollment form and for whom the required premium payment is paid.

C. The Excess Insurance provision appearing in SECTION V GENERAL PROVISIONS is deleted and will not appear.

D. SECTION V GENERAL PROVISIONS is amended to include the following provision at the end:
Required Ohio Statement regarding termination of Participating Organization or Master Group Policy: In the event of termination of the Participating Organization or the Master Group Policy, coverage issued under this Certificate for which the required premium payment has been paid prior to that termination date will continue until the end of Your Trip.

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Endorsement will govern.

T210-AE OH

The Policy/Certificate are hereby amended for Oklahoma as follows:

1. The third paragraph on the Face Page is deleted and replaced as follows:
OKLAHOMA
Insurance provided by this Certificate is subject to all the terms and conditions of the Group Policy, issued in a state other than Oklahoma. Certificates delivered to residents of Oklahoma are subject to the terms of this Certificate and not the Group Policy.
2. The following statement is added to the Face Page of the Certificate:
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information, is guilty of a felony.
3. Exclusion 2. pertaining to war appearing in SECTION IV General Exclusions is deleted and replaced as follows:
    2. war or any act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.
4. The last sentence in the Medically Fit to Travel Exclusion provision appearing in SECTION IV General Exclusions is deleted and replaced as follows:
If Coverage for a Trip is purchased and it is later determined that You, Family Member booked to travel with You were not Medically Fit to Travel, as defined in this Certificate Plan, at the time of purchase of Coverage for a Trip, the Coverage is cancelled and premium paid will be returned.
5. The Payment of Claims provision appearing in SECTION V General Provisions is deleted and replaced as follows:

If any benefit is payable to: (a) an Insured who is a minor or otherwise not able to give a valid release; or (b) the Insured's estate, We may pay up to $1,000 to the Insured's beneficiary or any relative whom We find entitled to the payment. Any payment made in good faith shall fully discharge Us to any party to the extent of such payment.

6. The Concealment and Misrepresentation provision appearing in SECTION V General Provisions is deleted and replaced as follows:
   Concealment and Misrepresentation: The entire coverage will be cancelled, if before, during or after a loss, any material fact or circumstance relating to this insurance has been concealed or misrepresented.
7. SECTION V General Provisions is amended to include the following provisions:
   Conformity with Oklahoma statutes: The provisions of this Certificate conform to the requirements of Oklahoma law and this Certificate controls over any conflicting statutes of any state in which You reside on or after the effective date of this Certificate.

Required Oklahoma Statement regarding premium: The exact amount of premium will be determined upon purchase of the coverage under this Certificate, and the basis and rates upon which the premium will be the determined are the plan design, Trip cost and age of the Insured. The average per Trip premium is $76.54 USD.

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Oklahoma Endorsement will govern.
T210-AE OK

The Certificate is hereby amended for Rhode Island as follows:

RHODE ISLAND

1. The definition of Family Member in SECTION II DEFINITIONS is deleted and replaced as follows:
   "Family Member" means any of the following: Your legal spouse (or common-law spouse where legal), legal guardian or ward, son or daughter (adopted, foster, step or in-law), brother or sister (includes step or in-law), parent (includes step or in-law), grandparent (includes in-law), grandchild, aunt, uncle, niece or nephew, a person who is a party to a civil union with You as Your dependent and spouse.
2. The Time of Payment of Claims provision in SECTION V GENERAL PROVISIONS are deleted and replaced as follows:
   Time of Payment of Claims: We, or Our designated representative, will pay the claim within 60 days after receipt of acceptable proof of loss.

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Endorsement will govern.
T210-AE RI

Rhode Island Guaranty Notice

COVERAGE, LIMITATIONS AND EXCLUSIONS UNDER
RHODE ISLAND LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT ("Act")

A resident of Rhode Island who purchases life insurance, annuities, or accident and health insurance should know that an insurance company licensed in Rhode Island to write these types of insurance is a member of the Rhode Island Life and Health Insurance Guaranty Association ("Association"). The purpose of the Association is to assure that a policyholder will be protected within the statutory limits, if a member insurer becomes financially unable to meet its obligations. If

this should happen, the Association will, within the statutory limits, pay the claims of insured persons who live in this state, and, in some cases, keep coverage in force.
However, the protection provided through the Association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

IMPORTANT DISCLAIMER
RHODE ISLAND LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
235 PROMENADE STREET, PROVIDENCE, RI 02908
TEL (401)273-2921

The Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Rhode Island. You should not rely on coverage by the Association in selecting an insurance company or an insurance policy. Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus or self-funded plans. Insurance companies or their agents are required by law to give or send you this summary. However, they are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy. Should you seek information as to the financial condition of any insurer or should you have any complaint as to an insurer's violation of the Act, you may contact the Division of Insurance at the address listed below.

RHODE ISLAND DIVISION OF INSURANCE
222 Richmond Street, Providence, RI 02903
TEL (401)222-2223

The full text of the state law that provides for this safety net coverage, Rhode Island Life and Health Insurance Guaranty Association Act, ("the Act"), can be found beginning at R.I. Gen. Laws sec. 27-34.3-1. A brief summary of the Act is provided below. This summary does not cover all provisions of the law, nor does it any way change your rights or obligations or those of the Association under the Act.

COVERAGE
Generally, individuals will be protected by the Association if the individual lives in Rhode Island and: Holds a life or health insurance contract or annuity contract; or is insured under a group insurance contract issued by a member insurer. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live elsewhere.

EXCLUSIONS FROM COVERAGE
The Association does NOT protect a person holding a policy if:
- the individual is eligible for protection under a similar law of another state;
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization that is not a member of the Association;
- the policy was issued by a nonprofit hospital or medical service organization (such as, the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments or by an insurance exchange.

The Association does not provide coverage for:

- a policy or portion of a policy not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus; a policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed a rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- an employer's plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of unallocated annuity contract not specified to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer.

LIMITATIONS ON COVERAGE

The Act limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurer would have owed under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were in force with the same insurer, the Association will pay no more than:

- $300,000 in net life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;
- $100,000 for health insurance benefits, coverages not defined as disability, basic hospital, medical, and surgical, or major medical insurance, or long-term care insurance, including any net cash surrender and net cash withdrawal values;
- $300,000 for disability insurance and $300,000 in long term care insurance;
- $500,000 for basic hospital, medical, and surgical and major medical insurance;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal value;
- $250,000 in present value per payee with respect to structured settlement annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- $300,000, in the aggregate, of the present value of annuity benefits, including net cash surrender and net cash withdrawal values, with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. sec.401, 403(b), or 457 and covered by an unallocated annuity contract, or to a beneficiary of the individual if the individual is deceased;
- $5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund governmental retirement plans under sections 401(k), 403(b), or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the Association be liable to spend more than $300,000 in the aggregate per

individual except hospital insurance up to $500,000 per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, the contract limits also apply.

These general statements as to Limitations on Coverage are only summaries of the law. The actual limitations are set forth in R.I. Gen. Laws sec. 27-34.3-3.

This information is provided by: The Association and by the Division of Insurance, whose respective addresses are provided in the Important Disclaimer, above. The Certificate is hereby amended for South Carolina as follows:

SOUTH CAROLINA

1. The Payment of Claims, Physical Examination and Autopsy and Legal Actions provisions in SECTION V GENERAL PROVISIONS are deleted and replaced as follows:
   Payment of Claims: Benefits will be paid to the Insured. Loss of Life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the Insured's estate. Any other benefits unpaid at death may be paid, at the Company's option, either to the Insured's beneficiary or estate.
   Physical Examination and Autopsy: The Company at its own expense may have the Insured examined as often as reasonably necessary while a claim is pending and in cases of death of the Insured the Company at its own expense also may have an autopsy performed during the period of contestability unless prohibited by law. The autopsy must be performed in South Carolina.
   Legal Actions: No legal action may be brought to recover on this Certificate within sixty days after written proof of loss has been given as required by this Certificate. No such action may be brought after six years from the time written proof of loss is required to be given.
2. The following provision is added as the last provision in SECTION V GENERAL PROVISIONS:
   Change of Beneficiary: The Insured can change the beneficiary at any time by giving the Company written notice. The beneficiary's consent is not required for this or any other change in the Certificate, unless the designation of the beneficiary is irrevocable.

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Endorsement will govern.
T210-AE SC

The Policy/Certificate are hereby amended for South Dakota as follows:

SOUTH DAKOTA

1. The following Exclusion 4. appearing in SECTION IV GENERAL EXCLUSIONS is deleted in its entirety:
   4. being intoxicated as defined herein, or under the influence of any controlled substance unless administered or prescribed by a Legally Qualified Physician";
2. The last sentence of the Legal Actions provision appearing in SECTION V GENERAL PROVISIONS is deleted and replaced as follows: No legal action for a claim may be brought against Us after 6 years from the time written Proof of Loss is required to be furnished.

If there is a conflict between the Policy/Certificate and this Rider, the terms of this Endorsement will govern. T210-AE SD

UTAH

1. The definition of Family Member appearing in SECTION II DEFINITIONS is amended to include a child placed for adoption with the Insured.
2. The definition of Complications of Pregnancy appearing SECTION II DEFINITIONS is deleted and replaced as follows:
   "Complications of Pregnancy" means diseases or conditions the diagnoses of which are distinct from pregnancy but are adversely affected or caused by pregnancy and not associated with a normal pregnancy. These conditions include acute nephritis, nephrosis, cardiac decompensation, ectopic pregnancy which is terminated, a spontaneous termination of pregnancy, which occurs during a period ofgestation in which a viable birth is not possible, puerperal infection, eclampsia, pre-eclampsia and toxemia.
   Complications of Pregnancy does not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness and similar conditions associated with the management of a difficult pregnancy.
3. The Proof of Loss provision appearing in SECTION V GENERAL PROVISIONS is amended to include the following sentence at the end of the provision:
   Failure to give notice or file proof of loss does not bar recovery under the Certificate if the Company fails to show that it was prejudiced by the failure to provide proof in a timely manner.
4. The Time of Payment of Claims provision appearing in SECTION V GENERAL PROVISIONS is deleted and replaced as follows:
   Time of Payment of Claims: We, or Our designated representative, will pay the claim within 30 days after receipt of acceptable proof of loss.

T210-AE UT

The Policy/Certificate are hereby amended for Vermont as follows:

VERMONT AMENDATORY ENDORSEMENT

A. The references to "Usual and Customary" are replaced by "Reasonable and Necessary".
B. The definition of "Usual and Customary" appearing in SECTION II DEFINITIONS will now appear as the definition of "Reasonable and Necessary".
C. The following exclusions appearing in SECTION IV GENERAL EXCLUSIONS are deleted and/or deleted and replaced as follows:
   4. riding or driving in races, or speed or endurance competitions or events, when racing in a professional capacity;
   5. deleted in its entirety (relating to mountaineering);
   7. participating in bodily contact sports, parachuting;
   16. deleted in its entirety (relating to device, weapon, material employing chemical, biological, radiological).
D. The Time of Payment of Claims provision appearing in SECTION V GENERAL PROVISIONS is deleted and replaced as follows:
   Time of Payment of Claims: We, or Our designated representative, after settlement has been agreed upon, will pay the claim in the agreed amount within 10 working days.
E. The last sentence in the Physician Examination and Autopsy provision appearing in SECTION V GENERAL PROVISIONS is deleted and replaced as follows: The Company may have an autopsy done (at the expense of the Company) unless the law or Your religion forbids it.
F. The following is added as the last sentence in the Legal Actions provision appearing in SECTION V GENERAL PROVISIONS:
   However, Your right to bring legal action against Us is not conditioned upon Your compliance with the provisions of any appraisal condition.
G. SECTION V GENERAL PROVISIONS is amended to include the following provision at the end of that section:

Vermont law regarding civil unions: Vermont law requires that insurance policies and certificates offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with Vermont law regarding civil unions, the civil union must be established in the state of Vermont according to Vermont law. It is understood that definitions and provisions within this Certificate designating Insured, Eligible Person, Family Member, You/and or Your and another other certificate definitions and provisions designating an Insured under this Certificate are amended, whenever appearing, where terms denoting a marital relationship or family relationship arising out of a marriage are used to indicate parties to a civil union and their families under Vermont law.

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Endorsement will govern.

T210-AE VT

The Certificate is hereby amended for Wyoming as follows:

WYOMING

1. In the definition of Pre-Existing Condition appearing in SECTION II DEFINITIONS, Item 1) is deleted and replaced as follows:
   1) received a recommendation for a test, examination, or medical treatment for a condition which first manifested itself, worsened or became acute, resulting in actual diagnosis, care or treatment received;

2. In the Pre-Existing Condition Exclusion provision appearing in SECTION IV GENERAL EXCLUSIONS, Item 1) is deleted and replaced as follows:
   1) received a recommendation for a test, examination, or medical treatment for a condition which first manifested itself, worsened or became acute, resulting in actual diagnosis, care or treatment received;

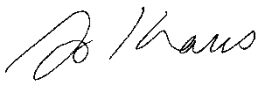
If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Endorsement will govern.

T210-AE WY

If there is a conflict between the Policy and the Endorsements, the terms of this Endorsement will govern.

Signed for **United States Fire Insurance Company** By:

Marc J. Adee
Chairman and CEO



James Kraus
Secretary

GRIEVANCE PROCEDURES

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

A **"Grievance"** is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of health care services, or other matters pertaining to your coverage and our contractual relationship.

An **"Adverse Determination"** is a determination by the Company or its designated utilization review organization that (i) a service, treatment, drug, or device, is experimental, investigational, specifically limited or excluded by your coverage; or (ii) a facility admission, the availability of care, continued stay or other health care services proposed or furnished have been reviewed and, based upon the information provided, does not meet the contractual requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore, the benefit coverage is denied, reduced or terminated in whole or in part.

INFORMAL GRIEVANCE PROCEDURE

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 60-days after an event that causes a dispute. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30-days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

A formal Grievance may be submitted by you, your authorized representative, or in the event of an Adverse Determination, by a provider acting on your behalf.

If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination.

First Level Review

Within 3 working business days after receiving the Grievance, we must acknowledge the Grievance and provide you, your authorized representative or a provider with the name, address, and

telephone number of the coordinator handling the Grievance and information on how to submit written material. The person(s) who reviews the Grievance will not be the same person(s) who made the initial Adverse Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, a First Level Review. The Insured may, however, submit written material for consideration by the reviewer(s).

Grievance

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter.

Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 20-days after receiving the Grievance. The written decision must include:

(1) The name(s), title(s) and professional qualifications of any person(s) participating in the First Level Review process.
(2) A statement of the reviewer's understanding of the Grievance.
(3) The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.
(4) A reference to the evidence or documentation used as the basis for the decision.
(5) If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
(6) A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review

The Second Level Review process is available if you are not satisfied with the outcome of the First level Review for an Adverse Determination. Within ten business days after receiving a request for a Second Level Review, we will advise you of the following:

(1) the name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;
(2) a statement of your rights, including the right to:
    - attend the Second Level Review
    - present his/her case to the review panel;
    - submit supporting materials before and at the review meeting;
    - ask questions of any member of the review panel;
    - be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney.
    - request and receive from us free of charge, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination.

We must convene a review panel and hold a review meeting within 45-days after receiving a request for a Second Level Review. We will notify you in writing of the meeting date at least 15-

days prior to the date. The review meeting will be held during regular business hours at a location reasonable accessible to you. In cases where a face-to-face meeting is not practical for geographic reasons, we will offer you the opportunity to communicate with the review panel at our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not you appear at the meeting.

If you choose to be represented by an attorney, we may also be represented by an attorney. If we choose to have an attorney present to represent our interests, we will notify you at least 15 working days in advance of the review that an attorney will be present and that you may wish to obtain legal representation of your own.

The panel must be comprised of persons who:

(1) were not previously involved in any matter giving rise to the Second Level Review;
(2) are not employees of the Company or Utilization Review Organization; and
(3) do not have a financial interest in the outcome of the review.

A person previously involved in the Grievance may appear before the panel to present information or answer questions.

All persons reviewing a Second Level Grievance involving a Utilization Review non-certification or a clinical issue will be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on a First Level Review, we may use one of our employees on the Second Level Review panel if the panel is comprised of 3 or more persons.

Grievance

We must issue a written decision to you and, if applicable, to your representative or provider, within 10 business days after completing the review meeting. The decision must include:

(1) the name(s), title(s) and qualifying credentials of the members of the review panel;
(2) a statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;
(3) the review panel's recommendation to the Company and the rationale behind the recommendation;
(4) a description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation;
(5) in the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination;
(6) the rationale for the Company's decision if it differs from the review panel's recommendation;
(7) a statement that the decision is the Company's final determination in the matter;
(8) notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED REVIEW

You are eligible for an expedited review when the timeframes for an Informal, formal First Level review or Second Level review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances

concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24-hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72-hours after the review has commenced. Written confirmation of our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements for First Level reviews.

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.

PRIVACY POLICY AND PRACTICES

The Company values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information about our customers. We want you to know that we are committed to protecting your private information and we will comply with all federal and state privacy laws. Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

Your Privacy is Our Concern
When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. There are legal requirements governing the collection, use, and disclosure of such information. The Company maintains physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs our employees as to the importance of the confidentiality of personal information, and takes measures to enforce employee privacy responsibilities.

What kind of information do we collect about you and from whom?
We obtain most of our information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts,

or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?
If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To whom do we disclose information about you?
We may disclose all the information that we collect about you, as described above. We may disclose such information about you to our affiliated companies, such as:

- Insurance companies;
- Insurance agencies;
- Third party administrators;
- Medical bill review companies; and
- Reinsurance companies.

We may also disclose nonpublic personal information about you to affiliated and nonaffiliated third parties as permitted by law. You have a right to access and correct the personal information we collect, maintain, and disclose about you.

How to contact Us
You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include your name, address, policy number, and daytime phone number.

Privacy Policy Coordinator
Fairmont Specialty
5 Christopher Way, 3rd Floor
Eatontown, New Jersey 07724