Tramont Insurance Company Limited Certificate

This Insurance is effected with Tramont Insurance Company Limited.

This Certificate is issued in accordance with the limited authorization granted to the Correspondent by Tramont Insurance Company Limited and in consideration of the premium specified herein.

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

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

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

CERTIFICATE PROVISIONS

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

2. Correspondent Not Insurer. The Correspondent is not an Insurer hereunder and neither is nor shall be liable for any loss or claim whatsoever. The Insurer hereunder is Tramont Insurance Company Limited.

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

4. Service of Suit. It is agreed that in the event of the failure of Tramont Insurance Company Limited to pay any amount claimed to be due hereunder, Tramont Insurance Company Limited, at the request of the Assured, will submit to the jurisdiction of a Court of competent jurisdiction within Tortola, British Virgin Islands. Nothing in this Clause constitutes or should be understood to constitute a waiver of Tramont's rights to commence an action in any Court of competent jurisdiction in Tortola, British Virgin Islands, to remove an action to a Tortola, British Virgin Islands Court, or to seek a transfer of a case to another Court as permitted by the laws of Tortola, British Virgin Islands. It is further agreed that service of process in such suit may be made upon Atlas Insurance Management (BVI) Limited, P.O. Box 129, Road Town, Tortola, British Virgin Islands and that in any suit instituted against any one of them upon this contract, Tramont Insurance Company Limited will abide by the final decision of such Court or of any Appellate Court in the event of an appeal.

The above-named are authorized and directed to accept service of process on behalf of Tramont Insurance Company Limited in any such suit and/or upon request of the Assured to give a written undertaking to the Assured that they will enter a general appearance upon Tramont's behalf in the event such a suit shall be instituted.

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

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

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

7. Short Rate Cancellation. If the attached provisions provide for cancellation, the table below will be used to calculate the short rate proportion of the premium when applicable under the terms of cancellation.

Short Rate Cancellation Table for Term of Three Hundred And Sixty-four (364) Days.

Days Insurance In Force	Per Cent of Coverage Period Premium	Days Insurance In Force	Per Cent of Coverage Period Premium	Days Insurance In Force	Per Cent of Coverage Period Premium	Days Insurance In Force	Per Cent of Coverage Period Premium
1	5 %	66 - 69	29 %	154 -	156 53 %	256 -	260 77 %
2	6	70 - 73	30	157 -	160 54	261 -	264 78
3 - 4	7	74 - 76	31	161 -	164 55	265 -	269 79
5 - 6	8	77 - 80	32	165 -	167 56	270 -	273 (9 mos.) 80
7 - 8	9	81 - 83	33	168 -	171 57	274 -	278 81
9 - 10	10	84 - 87	34	172 -	175 58	279 -	282 82
11 - 12	11	88 -91 (3 mos.)	35	176 -	178 59	283 -	287 83
13 - 14	12	92 - 94	36	179 -	182 (6 mos.) 60	288 -	291 84
15 - 16	13	95 - 98	37	183 -	187 61	292 -	296 85
17 - 18	14	99 -102	38	188 -	191 62	297 -	301 86
19 - 20	15	103 -	105 39	192 -	196 63	302 -	305 (10 mos.) 87
21 - 22	16	106 -	109 40	197 -	200 64	306 -	310 88
23 - 25	17	110 -	113 41	201 -	205 65	311 -	314 89
26 - 29	18	114 -	116 42	206 -	209 66	315 -	319 90
30 - 32 (1 mos.)	19	117 -	120 43	210 -	214 (7 mos.) 67	320 -	323 91
33 - 36	20	121 -	124 (4 mos.) 44	215 -	218 68	324 -	328 92
37 - 40	21	125 -	127 45	219 -	223 69	329 -	332 93
41 - 43	22	128 -	131 46	224 -	228 70	333 -	337 (11 mos.) 94
44 - 47	23	132 -	135 47	229 -	232 71	338 -	342 95
48 - 51	24	136 -	138 48	233 -	237 72	343 -	346 96
52 - 54	25	139 -	142 49	238 -	241 73	347 -	351 97
55 - 58	26	143 -	146 50	242 -	246 (8 mos.) 74	352 -	355 98
59 - 62 (2 mos.)	27	147 -	149 51	247 -	250 75	356 -	360 99
63 - 65	28	150 -	153 (5 mos.) 52	251 -	255 76	361 -	364 100

Rules applicable to insurance with terms less than or more than three hundred and sixty-four (364) days:

A. If insurance has been in force for three hundred and sixty-four (364) days or less, apply the short rate table for three hundred and sixty-four (364) days of insurance to the full Coverage Period premium determined as for insurance written for a term of three hundred and sixty-four (364) days.

B. If insurance has been in force for more than three hundred and sixty-four (364) days:
   1. Determine full Coverage Period premium as for insurance written for a term of three hundred and sixty-four (364) days.
   2. Deduct such premium from the full insurance premium, and on the remainder calculate the pro rata earned premium on the basis of the ratio of the length of time beyond three hundred and sixty-four (364) days the insurance has been in force to the length of time beyond three hundred and sixty-four (364) days for which the policy was originally written.
   3. Add premium produced in accordance with items (1) and (2) to obtain earned premium during full period insurance has been in force.

CERTIFICATE OF INSURANCE DECLARATIONS

Wander Frequent Traveler
TRA12-121022-10TM

This Declaration is attached to and forms part of certificate provisions

ITEM 1. NAMED INSURED AND MAILING ADDRESS: AS STATED ON THE ID CARD

Wander Frequent Traveler
c/o Atlas Insurance Management (BVI) Limited
P.O. Box 129, Road Town
Tortola, British Virgin Islands

ITEM 2. POLICY PERIOD: AS STATED ON THE ID CARD TERM: 364 days

[X] 12:01 A.M., North American Eastern Time

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

International Travel Medical Coverage:
Rates based on a $250 Deductible Effective May 1, 2012

Deductible Factors

Deductible Option	Deductible Factor
$0	1.50
$100	1.40
$250	1.00
$500	.90
$1000	.80
$2500	.70

TRAVELING TO THE UNITED STATES

If the applicant is traveling to, temporarily residing in, or visiting the United States, please use these rates.

	$60,000			$125,000			$600,000			$1,000,000		
Age Bands	Annual Premium	Administrative Fee	Annual Charge	Annual Premium	Administrative Fee	Annual Charge	Annual Premium	Administrative Fee	Annual Charge	Annual Premium	Administrative Fee	Annual Charge
19 - 29	$75.60	2%	$74.12	$100.40	2%	$98.43	$118.35	2%	$116.03	$127.35	2%	$124.85
30 - 39	$101.25	2%	$99.26	$135.07	2%	$132.42	$157.50	2%	$154.41	$168.30	2%	$165.00
40 - 49	$151.20	2%	$148.24	$193.55	2%	$189.75	$230.40	2%	$225.88	$244.35	2%	$239.56
50 - 59	$249.01	2%	$244.13	$322.40	2%	$316.08	$352.49	2%	$345.58	$380.70	2%	$373.24
60 - 64	$305.71	2%	$299.72	$405.20	2%	$397.25	$436.50	2%	$427.94	$480.60	2%	$471.18
65 - 69	$395.48	2%	$387.73	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
70 - 79	$473.85	2%	$464.56	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
80+*	$824.85	2%	$808.68	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child Alone	$76.05	2%	$74.56	$101.95	2%	$99.95	$111.60	2%	$109.41	$119.70	2%	$117.35
Dep Child	$45.90	2%	$45.00	$60.55	2%	$59.36	$68.85	2%	$67.50	$71.10	2%	$69.71

*Ages 80+ are limited to $20,000 in coverage

TRAVELING OUTSIDE THE U.S.

If the applicant is traveling outside the United States, use these rates. This includes U.S. citizens traveling overseas as well as persons traveling between countries, i.e., a Brazilian traveling to Spain.

	$60,000			$125,000			$600,000			$1,000,000		
Age Bands	Annual Premium	Administrative Fee	Annual Charge	Annual Premium	Administrative Fee	Annual Charge	Annual Premium	Administrative Fee	Annual Charge	Annual Premium	Administrative Fee	Annual Charge
19 - 29	$44.10	2%	$43.24	$52.48	2%	$51.45	$60.42	2%	$59.24	$65.27	2%	$63.99
30 - 39	$52.48	2%	$51.45	$64.83	2%	$63.56	$80.70	2%	$79.12	$90.45	2%	$88.68
40 - 49	$87.76	2%	$86.04	$97.90	2%	$95.98	$110.69	2%	$108.52	$118.19	2%	$115.87
50 - 59	$151.70	2%	$148.73	$171.11	2%	$167.75	$185.22	2%	$181.59	$188.31	2%	$184.62
60 - 64	$192.28	2%	$188.51	$227.12	2%	$222.67	$248.72	2%	$243.84	$269.45	2%	$264.17
65 - 69	$223.15	2%	$218.77	$239.46	2%	$234.76	$255.34	2%	$250.33	$279.15	2%	$273.68
70 – 79	$367.35	2%	$360.15	$489.51	2%	$479.91	N/A	N/A	N/A	N/A	N/A	N/A
80+*	$642.54	2%	$629.94	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child Alone	$48.51	2%	$47.56	$54.68	2%	$53.61	$60.86	2%	$59.67	$62.62	2%	$61.39
Dep Child	$32.19	2%	$31.56	$37.49	2%	$36.75	$41.01	2%	$40.21	$43.66	2%	$42.80

*Ages 80+ are limited to $20,000 in coverage

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

Dated: 10-22-2012

By:_____

(Correspondent – James J. Krampen, Jr.)

Wander℠ Frequent Traveler Program Summary

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

Quick Contacts

Hospital and Doctor Network: To locate a network facility in the United States, search online at www.sevencorners.com/networkproviders, contact Seven Corners Assist at the numbers shown below, or log onto WellAbroad.com.

To locate a facility outside of the United States, please contact Seven Corners Assist at the numbers shown below or log onto WellAbroad.com. Seven Corners Assist must be contacted prior to Hospital admission and/or any inpatient/outpatient surgeries.

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

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

Travel Assistance - To receive assistance worldwide, call Seven Corners Assist at the numbers below and provide them with Your ID Number. Seven Corners Assist must be contacted for Emergency Medical Evacuation, Return of Remains, Emergency Reunion, and Return of Minor Child.
Seven Corners Assist - In the United States, Canada, and the Caribbean (Toll-free): 1-800-690-6295 or Collect Calls : 0-317-818-2808
Email: assist@sevencorners.com

The Company hereby insures all persons whose Application has been accepted by the Administrator, Seven Corners, on behalf of the Company and whose name is identified on the ID Card, subject to all of the exclusions, limitations and provisions as set forth herein and in the Master Policy of insurance issued by the Company.

Coverage is afforded only with respect to the person, coverage, amounts and limits specified herein and as identified on the ID Card for the insurance requested on such Application and for which their specified plan costs have been paid to the Administrator.

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

PART I - INDIVIDUAL INSURANCE PROVISIONS

Eligibility

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

Effective Date of Individual Insurance

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

Termination Date of Individual Insurance

Individual coverage will end on the earlier of the following: 1) Three hundred and sixty-four (364) days after the effective date; or 2) The date shown on the ID Card, for which plan cost has been paid; 3) The date you are no longer eligible under this plan.; 4) The 30th day of any one trip; 5) When the maximum benefit amount has been paid.

Follow Me Home Coverage

Follow Me Home Coverage: This Policy shall pay for Covered Expenses incurred in your Home Country up to $5,000, minus Your Deductible and Coinsurance, for one hundred and eighty days (180) from the onset of a new covered Injury or Illness that is first diagnosed and treated outside Your Home Country. This benefit does not provide coverage for Pre-existing Conditions because the Exclusions for Medical Benefits apply.

If Seven Corners Assist evacuates/repatriates you to your Home Country for a Covered Injury or Illness, the $5,000 limit for Follow Me Home Coverage does not apply to the Medical Benefits.

Refund of Premium

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

All coverages and plan costs listed in this Evidence of Benefits are in U.S. Dollar amounts.	
Medical Maximums	$60,000; $125,000; $600,000; $1,000,000 Medical Maximum is per person per Period of Coverage. Insureds age 65 to 79 traveling inside the United States are limited to a $60,000 medical maximum. Insureds age 80 years and older traveling inside the United States are limited to a $20,000 medical maximum. Insureds age 70 to 79 traveling outside the United States are limited to a $125,000 medical maximum. Insureds age 80 years and older traveling outside the United States are limited to a $20,000 medical maximum.
Deductible	$0, $100, $250, $500, $1,000, $2,500. Deductible is per person per Period of Coverage. Maximum of 3 Policy Period Deductibles per family.
Coinsurance	Individuals traveling outside the U.S. & Canada: After You pay the Deductible, the Policy pays 100% to the selected Medical Maximum. Individuals traveling inside the U.S. & Canada*:* After You pay the Deductible, the Policy pays 90% of the next $5,000 of eligible expenses, then 100% to the selected Medical Maximum.
Hospital Indemnity	$150 per night, up to a maximum of 30 days (Applicable to Individuals traveling outside the U.S. and Canada only).
Dental (Sudden Relief of Pain)	To a maximum of $100 (Only available to programs purchased for 1 month or more.)
Dental (Accident Coverage)	To a maximum of $500 (Only available to programs purchased for 1 month or more.)
Emergency Medical Evacuation/Repatriation	$300,000 (in addition to the Medical Maximum)
Return of Mortal Remains	$50,000
Political Evacuation:	$50,000
Felonious Assault	$10,000
Coma Benefit	$50,000
Terrorism	Usual, reasonable and customary to $50,000 Lifetime Maximum
Return of Minor Child(ren)	$50,000
Emergency Reunion	$50,000
Local Ambulance Benefit	$5,000
Accidental Death & Dismemberment (AD&D) *Note: In the event of a Common Carrier Accidental Death, this benefit will not be paid.*	$50,000 principal sum for Insured or Insured Spouse $5,000 principal sum for Dependent Child(ren) Aggregate limit of $250,000 per family
Common Carrier Accidental Death	$100,000 principal sum for Insured or Insured Spouse $25,000 principal sum for Dependent Child(ren) Aggregate limit of $250,000 per family
Loss of Baggage	$250
Interruption of Trip	$5,000
Follow Me Home Coverage	$5,000
Hospital Room & Board	Usual, reasonable and customary to the selected Medical Maximum
Intensive Care	Usual, reasonable and customary to the selected Medical Maximum
Outpatient Medical Expenses	Usual, reasonable and customary to the selected Medical Maximum
Waiver of Pre-existing Conditions	Available only for U.S. citizens traveling outside the United States and Canada.
Heart Attack and Stroke	Up to $200 per day for each night spent in the hospital after being admitted for either a heart attack or stroke. (For foreign nationals visiting the United States only)
Benefit Period	180 Days
Hazardous Sport Coverage	Optional, provided only if required premium is paid.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

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

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

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

Common Carrier Benefit

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

MEDICAL EXPENSE BENEFITS

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

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

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

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

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

COMA BENEFIT

Maximum Benefit Amount: $50,000

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

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

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

FELONIOUS ASSUALT BENEFIT

Maximum Benefit Amount: $10,000

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

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

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

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

HOSPITAL INDEMNITY

Should the Insured Person be hospitalized while traveling outside the United States or Canada, and the hospitalization is considered a Covered Expense, the Company will indemnify the Insured $150 for each night spent in the hospital up to a maximum of thirty (30) days. This payment is not related to the actual hospital charges and is paid in addition to any other Eligible Benefits. You may use these funds for incidentals or as you like.

EMERGENCY MEDICAL EVACUATION/REPATRIATION

Maximum Benefit Amount: $300,000

The Emergency Medical Evacuation or Repatriation must be arranged by Seven Corners Assist in consultation with the Insured Person's local attending Physician. Failure to utilize Seven Corners Assist to arrange for these services will result in the denial of benefits.

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

Emergency Medical Evacuation or Repatriation means: (a) the Insured Person's medical condition warrants immediate transportation from the place where the Insured Person is located to the nearest adequate medical facility where medical treatment can be obtained; or (b) after being treated at a local medical facility as a result of a Emergency Medical Evacuation, the Insured Person's medical condition warrants transportation with a qualified medical attendant to his/her Home Country to obtain further medical treatment or to recover; or (c) both (a) and (b) above. All transportation arrangements must be by the most direct and economical route.

REPATRIATION OF REMAINS

Maximum Benefit Amount: $50,000

The Company will pay the reasonable Covered Expenses incurred up to $50,000 to return the Insured Person's remains to his/her then Home Country, if he or she dies. Covered Expenses include, but are not limited to, cremation, expenses for embalming, a minimally necessary container appropriate for transportation, shipping costs, and the necessary government authorizations. Failure to utilize Seven Corners Assist to arrange for these services will result in the denial of benefits.

POLITICAL EVACUATION AND REPATRIATION OF REMAINS

Maximum Benefit Amount: $50,000

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

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

The Political Evacuation and Repatriation of Remains Benefit will not pay, should the Insured not heed Travel Warnings issued by the State Department or the appropriate authorities recommending that travelers avoid a certain country.

EMERGENCY MEDICAL REUNION

Maximum Benefit Amount: $50,000

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

RETURN OF MINOR CHILD(REN)

Maximum Benefit Amount: $50,000

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

INTERRUPTION OF TRIP

Maximum Benefit Amount: $5,000

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

LOSS OF CHECKED LUGGAGE

Maximum Benefit Amount: $250

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

DENTAL - EMERGENCY ONLY

Maximum Benefit Amount: $500

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

TERRORISM

Maximum Benefit Amount: $50,000

Coverage for Eligible Benefits resulting from Terrorist Activity, subject to a $50,000 Lifetime Maximum, provided all of the following conditions are met:

1. The Insured Person has no direct or indirect involvement in the Terrorist Activity.
2. The Terrorist Activity is not in a country or location where the United States government has issued a travel warning that has been in effect within the six (6) months prior to the Insured Person's date of arrival.
3. The Insured Person has not unreasonably failed or refused to depart a country or location following the date a warning to leave that country or location is issued by the United States government.

HAZARDOUS SPORTS COVERAGE *(when applicable)*

To cover motorcycle/motor scooter riding *(whether as a passenger or driver),* hang gliding, parachuting, bungee jumping, water skiing, snow skiing, snowmobiling, snow boarding,and spelunking. Coverage is provided only if the required premium has been paid.

PART III - DEFINITIONS

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

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

The term "Company" shall mean Tramont Insurance Company Limited.

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

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

The term "Congenital" shall mean a physical abnormality or condition that is present at birth, whether inherited or caused by the environment.

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

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

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

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

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

The term “Experimental / Investigational” means all services or supplies associated with: 1) treatment or diagnostic evaluation which is not generally and widely accepted in the practice of medicine in the United States of America or which does not have evidence of effectiveness documented in peer reviewed articles in medical journals published in the United States. For the treatment or diagnostic evaluation to be considered effective such articles should indicate that it is more effective than others available: or if less effective than other available treatments or diagnostic evaluations, is safer or less costly; 2) A drug which does not have FDA marketing approval; 3) A medical device which does not have FDA marketing approval; or has FDA approval under 21 CFR 807.81, but does not have evidence of effectiveness for the proposed use documented in peer reviewed articles in medical journals published in the United States. For the device to be considered effective, such articles should indicate that it is more effective than other available devices for the proposed use; or if less effective than other available devises, or is safer or less costly. The company will make the final determination as to whether a service or supply is Experimental/Investigational.

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

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

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

The term "Illness" wherever used in this Policy shall mean a sickness, disorder, illness, pathology, abnormality, malady, morbidity, affliction, disability, defect, handicap, deformity, birth defect, congenital defect, symptomatology, syndrome, malaise, infection, infirmity, ailment, disease of any kind, or any other medical, physical or health condition. Provided, however, that Illness does not include learning disabilities, or attitudinal or disciplinary problems. All Illnesses that exist simultaneously or which arise subsequent to a prior Illness and which directly or indirectly relate to or result or arise from the same or related causes or as a consequence thereof or from one another are considered to be one Illness. Further, if a subsequent Illness results or arises from causes or consequences that are the same as or related to the causes or consequences of a prior Illness, the subsequent Illness will be deemed to be a continuation of the prior Illness and not a separate Illness.

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

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

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

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

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

The term “Mental Illness” and “Mental and Nervous Disorder” shall mean any mental, nervous, or emotional Illness which generally denotes an Illness of the brain with predominant behavioral symptoms; or an Illness of the mind or personality, evidenced by abnormal behavior; or an Illness or disorder of conduct evidenced by socially deviant behavior. Mental or Nervous Disorders include without limitation: psychosis; depression; schizophrenia; bipolar affective disorder; any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases as published by the U.S. Department of Health and Human Services; and those psychiatric and other Mental Illnesses listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders published by the American Psychiatric Association. Mental Illness and Mental and Nervous Disorder does not mean or include learning disabilities, attitudinal disorders or disciplinary problems. For purposes of this insurance, Mental Illness and Mental and Nervous Disorder do not include Substance Abuse.

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

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

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

The term “Pre-Existing Condition” as used in this Policy shall mean any medical condition, sickness, Injury, Illness, disease, Mental Illness or Mental Nervous Disorder, regardless of the cause including any congenital, chronic, subsequent, or recurring complications or consequences related thereto or resulting therefrom that with reasonable medical certainty existed at the time of application or any time during the 36* months prior to the effective date of coverage under this policy, whether or not previously manifested , symptomatic, known, diagnosed, treated or disclosed. This specifically includes but is not limited to any medical condition, sickness, Injury , Illness, disease , Mental Illness or Mental Nervous Disorder, for which medical advice, diagnosis, care or treatment was recommended or received or for which a reasonably prudent person would have sought treatment during the 36 month period immediately preceding the effective date of coverage under this policy. *For Insured Persons traveling outside the United States and Canada, the period is 12 months instead of 36 months.

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

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

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

The term “Sound Natural Tooth” or “Sound Natural Teeth” is a tooth that is whole or properly restored; is without impairment, periodontal or other conditions; is not more susceptible to Injury than a virgin tooth, and is not in need of the treatment provided for any reason other than Accidental Injury. A tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or Treated by endodontics, is not a Sound Natural Tooth.

The term “Substance Abuse” shall mean a condition brought about when an individual uses alcohol, chemicals or any other drug(s) in such a manner that his/her health and/or judgement is impaired and/or ability to control actions is lost.

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

The term “Terrorist Activity” shall mean an act, or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist activity can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of terrorist activity can either be acting alone, or on behalf of, or in connection with any organization(s) or governments(s).

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

PART IV – EXCLUSIONS

For Medical benefits, this Insurance does not cover:

1. Pre-existing Conditions which are excluded under this policy. This means that any claims for Pre-existing Conditions will not be covered for the duration of this policy.
    a) If you are a United States citizen and the United States is your Home Country, this exclusion is waived for the first $20,000 in eligible medical expenses incurred outside the United States and Canada *(for persons age 65 and over, the amount is $2,500)*. This waiver does not include coverage for known, scheduled, required, or expected medical care, drugs, or treatments existent or necessary prior to the effective date of this program.
    b) If you are a non-United States citizen and suffer a Myocardial Infarction or Stroke and are admitted to a Hospital, this exclusion is waived in order to pay a $200 per night benefit for each night spent in the Hospital, up to a maximum benefit of $3,000. The term “Myocardial Infarction” shall mean an acute and emergent onset of the condition. The term “Stroke” shall mean an acute and emergent onset of the condition.
2. Charges for treatment which exceed Reasonable and Customary charges; or Charges incurred for Surgeries or treatments which are Investigational, Experimental, or for research purposes; expenses which are nonmedical in nature; expenses for Vocational, Speech, Recreational or Music Therapy;
3. Claims not received by Seven Corners within ninety (90) days of the date of service;
4. Expenses which were not recommended, approved and certified as Medically Necessary and reasonable by a Physician;
5. Suicide or any attempt thereof, while sane or self destruction or any attempt thereof, while insane; intentionally self-inflicted Injury or Illness; or expenses as a result or in connection with the commission of a felony offense;
6. War, hostilities or warlike operations (whether war be declared or not), Invasion, Act of an enemy foreign to the nationality of the Insured Person or the country in, or over, which the act occurs, Civil war, Riot, Rebellion, Insurrection, Revolution, Overthrow of the legally constituted government, Civil commotion assuming the proportions of, or amounting to, an uprising, Military or usurped power, Explosions of war weapons, Utilization of Nuclear, Chemical or Biological weapons of mass destruction howsoever these may be distributed or combined, Murder or Assault subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the Insured Person whether war be declared with that state or not. For the purpose of this Exclusion ii) Utilization of Nuclear weapons of mass destruction means the use of any explosive nuclear weapon or device or the emission, discharge, dispersal, release or escape of fissile material emitting a level of radioactivity capable of causing incapacitating disablement or death amongst people or animals (including in connection with an Terrorist Activity). iii) Utilization of Chemical weapons of mass destruction means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing incapacitating disablement or death amongst people or animals (including in connection with an Terrorist Activity). iv) Utilization of Biological weapons of mass destruction means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which are capable of causing incapacitating disablement or death amongst people or animals (including in connection with an Terrorist Activity). Also excluded hereon is any Loss or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, or suppressing any, or all, of the situations described above. In the event any portion of this exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and effect;
7. Terrorist Activity. For the purpose of this Exclusion, Terrorist Activity means an act, or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist Activity can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of Terrorist Activity can either be acting alone, or on behalf of, or in connection with any organization(s) or governments(s).The Company shall not be liable for and will not provide coverage or benefits in excess of a $50,000 lifetime maximum benefit for any claim or charges, Illness, Injury or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising in connection with any act of Terrorism; and provided, further, the Company shall not be liable for and will not provide any coverage or benefits for any claim, charges, Illness, Injury or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising in connection with the following:
    a) The Insured Person’s direct or indirect involvement in the Terrorist Activity.
    b) The Terrorist Activity takes place in a country or location where the United States government has issued a travel warning that has been in effect within the six (6) months prior to the Insured Person’s date of arrival.
    c) The Insured Person unreasonably fails or refuses to depart a country or location following the date a warning to leave that country or location is issued by the United States government.
8. Injury sustained while participating in professional, sponsored and/or organized Amateur or Interscholastic Athletics;
9. Routine physicals, inoculations, or other examinations where there are no objective indications or impairment in normal health;
10. Treatment of the Temporomandibular joint;
11. Services or supplies performed or provided by a Relative of the Insured Person, or anyone who lives with the Insured Person;
12. Treatment and the provision of false teeth or dentures, normal ear tests and the provision of hearing aids, cosmetic or plastic Surgery (including deviated nasal septum), routine dental expenses, eye refractions or eye examinations for the purpose of prescribing corrective lenses for eye glasses or for the fitting thereof, unless caused by Accidental bodily Injury incurred while insured hereunder;
13. Treatment in connection with alcohol, drug or chemical abuse, misuse, illegal use, overuse or dependency or use of any drug or narcotic agent; Injury sustained while under the influence of or Disablement due wholly or partly to the effects of intoxicating liquor, chemicals, or drugs or narcotic agent,unless administered under the advice of a Physician and said narcotic agent was taken in accordance with the proper dosing as directed by the physician;
14. Any Mental and Nervous disorders or Rest Cures;
15. Congenital abnormalities and conditions arising out of or resulting therefrom;
16. Learning disabilities, attitudinal disorders, or disciplinary problems;
17. Expenses incurred during a hospital emergency room visit which is not of an emergency nature;
18. Injury sustained while taking part in mountaineering, hang gliding, parachuting, bungee jumping, racing by horse or motor vehicle or motorcycle *(whether as a passenger or driver)*, snowmobiling, motorcycle/motor scooter riding, scuba diving involving underwater breathing apparatus (unless PADI or NAUI certified), water skiing, snow skiing and snow boarding *(UNLESS HAZARDOUS SPORTS RIDER IS PURCHASED, see section labeled Hazardous Sports Coverage)*

- Mountaineering shall mean the sport, hobby or profession of walking, hiking, and climbing up mountains either: 1) utilizing harnesses, ropes, crampons or ice axes; or 2) ascending 4500 meters or above.
- Parachuting shall mean an activity involving the breaking of a free fall from an airplane using a parachute.

19. Treatment paid for or furnished under any other individual, government, or group policy or charges provided at no cost to the Insured Person;
20. Treatment of venereal or sexually transmitted disease;
21. Sex change operations, or for treatment of sexual dysfunction or sexual inadequacy;
22. Expenses resulting from Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or the Human Immunodeficiency Virus (HIV);
23. Pregnancy expenses or Illness resulting from pregnancy, childbirth, or miscarriage; or for miscarriage resulting from an Accident;
24. Drug, treatment or procedure that either promotes or prevents conception, or prevents childbirth, including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal thereof;
25. Expenses incurred while the Insured Person is in their Home Country (except after approved Emergency Medical Evacuation/Repatriation or if treatment is a follow-up to a covered disablement during coverage, see Follow Me Home Coverage);
26. Expenses incurred for which travel was undertaken to seek medical treatment for a condition; or incurred after the Insured Person's physician has limited or restricted travel.

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

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

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

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

PART V - POLICY PROVISIONS

1. Notice of Claim: Written notice of claim must be given to the Company within ninety (90) days after the occurrence or commencement of any Disablement covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Administrative Offices of the Company, or to any authorized agent of the Company, with information sufficient to identify the Insured Person shall be deemed notice to the Company.
2. Claim Forms: The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the requirements of the Policy as to Proof of Loss upon submitting, within the time fixed in the Policy for filing Proofs of Loss, written proof covering the occurrence, the character and the extent of the Disablement for which claim is made.
3. Proof of Loss: Written Proof of Loss must be furnished to the Company at its said office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the Company is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible. The Company at its option may pend resolution and adjudication of submitted claims and/or deny coverage for Proof of Loss submitted thereafter, or for incomplete Proof of Loss and/or failure to submit Proof of Loss.
4. Time of Payment of Claims: Indemnities payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written Proof of Loss, all accrued indemnities for loss for which the Policy provides periodic payment will be paid at the expiration of each four (4) weeks during the continuance of the period for which the Company is liable, and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.
5. Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Insured Person. Any other accrued indemnities unpaid at the Insured Person's death may, at the option of the Company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Insured Person.
   If any indemnity of the Policy shall be payable to the estate of an Insured Person, or to an Insured Person who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding $1,000, to any Relative by blood or connection by marriage of the Insured Person who is deemed by the

Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

Subject to any written direction of the Insured Person all or a portion of any indemnities provided by this Policy on account of Hospital, nursing, medical or Surgical service may, at the Company's option and unless the Insured Person requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the Hospital or person rendering such services, but it is not required that the service be rendered by a particular Hospital or person.

6. Physical Examination and Autopsy: The Company at its own expenses shall have the right and opportunity to examine the person of any individual whose Injury or Illness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.
7. Legal Actions: No actions at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty (60) days after written Proof of Loss has been furnished in accordance with requirements of this Policy. No such action shall be brought after expiration of three (3) years after that time written Proof of Loss is required to be furnished.
8. Patient Protection and Affordable Care Act: This insurance is not subject to, and does not provide certain insurance benefits required by the United States Patient Protection and Affordable Care Act ("PPACA"). The insurance benefits provided by this policy are stated in your policy documents and do not include any additional benefits required by the PPACA. The PPACA requires certain U.S. residents and citizens to obtain PPACA compliant insurance coverage. In certain circumstances penalties may be imposed on U.S. residents and citizens who do not maintain PPACA compliant insurance coverage. You should consult your attorney, insurance agent, or tax professional to determine if the PPACA's requirements are applicable to you.
9. Coordination of Benefits: The Company coordinates benefits with other payers when an Insured Person(s) is covered by two (2) or more health plans. Coordination of Benefits is the industry standard practice used to share the cost of care between two (2) or more carriers when an Insured Person(s) is covered by more than one (1) health benefit plan. Our Coordination of Benefits and Services provision is attached hereto as APPENDIX A.

Excess Coverage

The Company will reduce the amount payable under this Policy to the extent expenses are covered under any Other Policy. The Company will determine the amount of benefits provided by Other Policies according to the Coordination of Benefits and Services provision attached hereto as Appendix A. The amount from Other Policies includes any amount to which the Insured Person is entitled, whether or not a claim is made for the benefits. This Policy is secondary coverage to all Other Policies.

Subrogation

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

Coverage Intent

Please be aware that this is not a general health insurance policy but an interim travel medical program intended for use while away from your Home Country or Country of Residence.

Pre-Notification and Network Information

1. Pre-Notification - You or someone on Your behalf are required to contact Seven Corners Assist in the following situations:
   a) Within 48 hours of an emergency hospital admission anywhere in the world.
   b) Before a scheduled, non-emergency hospital admission anywhere in the world.
   c) Before receiving any medical treatment inside the United States.
   d) Before inpatient or outpatient surgery worldwide.

   Pre-Notification does not guarantee that benefits will be paid.

2. Network
   a) Inside of the United States: Seven Corners' provider network is not required. By utilizing the network, You may receive potential discounts and out-of-pocket savings for any incurred eligible expenses.
   b) Outside of the United States: Seven Corners has an extensive network of international providers, many of which have direct pay agreements. We recommend You contact Seven Corners Assist for a provider referral, however, You may seek treatment at any facility.

   Utilizing the network does not guarantee benefits or that the treating facility will bill Seven Corners direct.

Contact information for Seven Corners Assist is provided below and on the back of Your virtual ID Card. Our multilingual representatives are available 24/7 to help you. Contact us immediately for Emergency Medical Evacuation, Return of Remains, Emergency Reunion, and Return of Minor Child(ren).

A listing of network providers can be found at www.sevencorners.com/networkproviders or by contacting Seven Corners Assist.
In addition, WellAbroad.com provides a complete listing of providers as well as other important and varied up-to-date travel information.

Seven Corners Assist
Inside the United States: 1-800-690-6295
Outside the United States: 0-317-818-2808 (Collect)
Fax: 1-317-815-5984
E-mail: assist@sevencorners.com

Wellabroad.com

In our ever changing world, Seven Corners' WellAbroad® seeks to prepare individuals and groups with the advanced tools for successful travel. WellAbroad® offers medical, political and cultural information and includes many benefits and educational resources, such as:

• Text messaging alerts - Registered users receive updates regarding weather emergencies, security issues, custom alerts, and health care or pandemic warnings.
• Provider network directory - Clients and travelers can create customized country profiles which allow instant access to providers in the specified regions to which they are traveling.
• Online forums - Fellow travelers and Seven Corners' staff post experiences and travel tips which can be accessed at any time.

Claims Services

Important Note: Claim forms and receipts for medical expenses must be sent to Seven Corners quickly. Claim submissions must be made within ninety (90) after the Date of Service. Should they be received after ninety (90) days, they may be considered ineligible.

To report claims or verify eligibility, send the original bills and claim forms to Seven Corners, Inc., or call or fax to the numbers below.
Be certain to include Your ID# shown on the ID Card with all correspondences:

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

Insurance Company

This Insurance, under Policy Number TRA12-121022-10TM, is underwritten by Tramont Insurance Company Limited.

Appendix A - COORDINATION OF BENEFITS AND SERVICES

Purpose of This Provision

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

DEFINITIONS

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

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

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

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

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

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

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

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

Plan does not include:

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

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

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

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

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

PRIMARY AND SECONDARY PLAN

The Company considers each plan separately when coordinating payments.

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

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

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

RULES FOR THE ORDER OF BENEFIT DETERMINATION

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

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

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

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

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

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

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

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

Procedures to be Followed by the Secondary Plan to Calculate Benefits

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

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

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

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

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

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

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

The secondary plan shall pay the lesser of:

a) The difference between the amount of the billed charges and the amount paid by the primary plan; or
b) The amount the secondary plan would have paid if it had been the primary plan.

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

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

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

a) The amount of any deductible, coinsurance or copayment required by the primary plan; or
b) The amount the secondary plan would have paid if it had been the primary plan.

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

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

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

a) The difference between the amount of the billed charges for the Allowable Charges and the amount paid by the primary plan; or
b) The amount the secondary plan would have paid if it had been the primary plan.

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

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

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

a) The amount of any deductible, coinsurance or copayment required by the primary plan; or
b) The amount the secondary plan would have paid if it had been the primary plan.

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

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

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

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

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

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

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

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

Primary Plan is an HMO and Secondary Plan is an HMO

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

SEVERABILITY OF INTEREST CLAUSE

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

TRAMONT INSURANCE COMPANY LIMITED PRIVACY POLICY STATEMENT

Tramont Insurance Company Limited wants you to know how we protect the confidentiality of your non-public personal information. We want you to know how and why we use and disclose the information that we have about you. The following describes our policies and practices for securing the privacy of our current and former customers.

INFORMATION WE COLLECT

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

INFORMATION WE DISCLOSE

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

CONFIDENTIALITY AND SECURITY

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

RIGHT TO ACCESS OR CORRECT YOUR PERSONAL INFORMATION

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

CONTACTING US

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