Master Policy #131920-4VSTSCR
[VISITORSECURE^{SM}]
Assured: The Atlas/International Citizen Group Insurance Trust
Hamilton, Bermuda

ARTICLE 1 - INSURING

Certain Underwriters at Lloyd's, London ("Underwriters") promise to provide the benefits described in this Master Policy. Underwriters make this promise in consideration of the Assured's Application, each Member's Application and payment of Premium.

HCC Medical Insurance services, LLC is hereby recognized by Underwriters as the Plan Administrator. All communications, notices and payments required under this Master Policy shall be transmitted through the Plan Administrator. Receipt by the Plan Administrator shall be considered receipt by Underwriters.

Patient Protection and Affordable Care Act ("PPACA"): This insurance is not subject to, and does not provide certain of the insurance benefits required by, the United States PPACA. In no event will Underwriters provide benefits in excess of those specified in the policy documents, and this insurance is not subject to guaranteed issuance or renewal. 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 PPACA's requirements are applicable to you.

Underwriter's agreement is subject to all terms, conditions, provisions and exclusions of this Master Policy, including any Exhibits, Schedules, Endorsements and/or Riders attached hereto.

ARTICLE 2 - EFFECTIVE DATE AND TERMINATION

This Master Policy is effective as of September 1, 2013 and shall remain in effect until August31, 2014. Thereafter, this Master Policy may be renewed for successive 12 month periods. This Master Policy can be terminated at any time by either Underwriters or the Assured giving at least 30 days advance written notice to the other party. Such termination of the Master Policy will have no effect on Certificates issued to Members prior to the date of termination or on payments made or to be made by or to Underwriters under such Certificates. No Certificates will be issued after the date the Master Policy is terminated.

ARTICLE 3 – GENERAL PROVISIONS

A. ENTIRE AGREEMENT

This Master Policy, including any Exhibits, Schedules, Endorsements and/or Riders attached hereto, constitutes the entire agreement between Underwriters and the Assured. The Certificate issued to the Member, including the Member's Application and any Exhibits, Schedules, Endorsements and/or Riders attached thereto, is an outline of the insurance provided by this Master Policy. The Certificate does not extend or change the insurance provided by this Master Policy. The insurance described in the Certificate is subject to all terms, conditions, provisions and exclusions of this Master Policy, including any Exhibits, Schedules, Endorsements and/or Riders attached hereto.

B. INSOLVENCY

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors or dissolution of the Assured or any Member shall not impose upon Underwriters any liability other than that specifically included in this insurance.

C. CURRENCY

The monetary limits and Premiums stated in this Master Policy and any Certificate issued hereunder are in U.S. dollars.

D. NOTICE

Any notice to any Member shall be placed in the United States Mail, postage prepaid, and addressed to the Member's mailing address on file with Underwriters on the date the notice is mailed. Members are required to promptly notify Underwriters of any change in mailing address.

ARTICLE 4 – CONDITIONS PRECEDENT

The following are conditions precedent to Underwriter's liability under this insurance:

A. PREMIUM

1. Rates: Rates shall be as set forth in Exhibit B attached hereto.
2. Payment: Payment of the required Premium shall be remitted to Underwriters on or before the Member's Certificate Effective Date, or continuation date (if applicable).
3. Premiums are fully earned on the Certificate Effective Date and are non-refundable thereafter.
4. Premium is considered to be paid on the date the payment instrument is received by Underwriters, provided such instrument provides immediately available funds.

B. MISREPRESENTATION AND FRAUD

1. Application:
   Underwriters rely on the statements made by the Member on the Application and in connection with the making of the Application in determining whether or not the individual(s) included on the Application meets the Eligibility requirements and the underwriting requirements for insurance hereunder. Any misstatement, concealment or fraud in the Member's Application, or in relation to any statement or warranty made by the Member or their authorized representative, whether in writing or otherwise, to Underwriters or their representatives, on or in connection with the Application shall render this insurance null and void and all claims hereunder shall be forfeited, in addition to any and all other remedies available to Underwriters.

2. Claims:
   Underwriters rely on the statements made by the Member on the Claimant's Statement and in connection with the submission of any claim hereunder in determining whether or not and to what extent benefits under this insurance may be payable. Any misstatement, concealment or fraud in the making of any claim hereunder shall render this insurance null and void and all claims hereunder shall be forfeited, in addition to any and all other remedies available to Underwriters. If any claim under this insurance shall be in any respect fraudulent or if any fraudulent

means or devices are used by the Member or anyone acting on their behalf, this insurance shall be null and void and all claims hereunder shall be forfeited, in addition to any and all other remedies available to Underwriters.

C. PROOF OF CLAIM

When Underwriters receive notice of claim, they will provide the Member with forms for filing Proof of Claim. The following is considered to be Proof of Claim:

1. A completed and signed Claimant's Statement and Authorization form, together with any/all required attachments; and
2. Original itemized bills from Physicians, Hospitals and other medical providers; and
3. Original receipts for any expenses which have already been paid by or on behalf of the Member.

The Member shall have 60 days beginning on the Certificate Termination Date to submit Proof of Claim to Underwriters. Subsequent to receipt of Proof of Claim, Underwriters may, at their sole discretion, request and require additional information, including but not limited to medical records, necessary to confirm the validity of any claim prior to payment thereof.

D. APPEALING A CLAIM

1. TIME LIMIT

In the event Underwriters deny all or part of a claim under this insurance, the Member shall have 90 days from the date the notice of denial was mailed to the Member's last known address to file a written appeal with Underwriters. The written appeal must include sufficient information to identify the claim under appeal and must specify the reason(s) for the appeal with supporting documentation, if applicable.

2. APPEAL PROCEDURE

Within 30 days of Underwriters' receipt of the appeal, Underwriters' will review the claim. A written response will be forwarded to the Member. Within 60 days of receipt of Underwriters' response to the appeal, the Member may initiate a second appeal. Within 30 days of Underwriters' receipt of the second appeal, medical and/or claims personnel who were not involved in the original claim determination or the initial appeal will review the claim. A final determination will be made and a letter will be sent to the Member.

E. ARBITRATION

If any dispute shall arise as to the amount to be paid under this insurance (liability being otherwise admitted), such dispute shall be referred to arbitration in accordance with procedures of the American Arbitration Association. Where any dispute is by this provision referred to arbitration, the making of an award shall be a condition precedent to any right of action against Underwriters.

F. LEGAL ACTIONS

No action of law or equity may be brought to recover benefits under this insurance until 60 days after written Proof of Claim, as herein defined, has been provided to Underwriters. No such action may be brought after the end of three (3) years after the time written Proof of Claim, as herein defined, is required to be furnished.

G. WAIVER OF RIGHTS

Failure by Underwriters to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether or not the circumstances are the same.

H. CLAIMS COOPERATION

The Member and his/her Physician(s), Hospital(s) and other providers shall cooperate fully with Underwriters including granting full right of access to all related medical documentation, reports and evidence. Underwriters may deny coverage for any claim where there has been a refusal or material failure to so cooperate.

I. PATIENT ADVOCACY

Underwriters may determine that a particular claim or diagnosis occurring under this insurance may be placed under the Patient Advocacy program to ensure that Medically Necessary services and supplies are provided in the most cost effective manner. In the event Underwriters determine that a claim or diagnosis meets the Patient Advocacy program requirements, they will notify the Member, and a Patient Advocate will be assigned to the Member. Thereafter, the Patient Advocate may make recommendations of alternative treatment settings and/or procedures and/or supplies, which may be more cost effective for the Underwriters and/or the Member. Such recommendations will be made with input from the Member and the Member's Physician(s) and will be made only when it can be reasonably demonstrated that the Medically Necessary services and supplies can be provided in a more cost-effective manner to Underwriters and/or the Member. Underwriters will use best efforts to evaluate and recommend alternative treatment settings and/or procedures and/or supplies, which can reasonably be expected to result in the same or better care of the Member. The Member, in accepting the recommendations, agrees to hold Underwriters harmless and Underwriters shall not be held liable or otherwise responsible for any treatment, service, supply, procedure or care provided to the Member except for the payment of benefits under this insurance. After the Member has been notified that the claim or diagnosis meets the Patient Advocacy program requirements, Underwriters reserve the rights to:

1. Make payment for treatments, services and/or supplies which are not covered under this insurance which would be beneficial to the Member and cost effective to Underwriters; and
2. Deny payment for expenses which would otherwise be covered under this insurance which are over the amount Underwriters would have paid had the Member followed the recommendations of the Patient Advocacy program.

J. SUBROGATION

Members undertake to cooperate with Underwriters in the prosecution of any and all valid claims they may have against third parties arising out of any occurrence which results or may result in a loss payment by Underwriters and to account for any amounts recovered on the basis that Underwriters shall be entitled to recover first in full any sums paid by them before the Member shares in any amount so recovered. Should the Member fail to prosecute any valid claims against third parties and Underwriters thereupon become liable to make payment under this insurance, then Underwriters shall be subrogated to all rights of the Member. Any amount recovered by Underwriters shall be used to pay the expenses of

collection and reimbursement of Underwriters for any amount that it may have paid or become liable to pay under this insurance. Any remaining amounts shall be paid to the Member.

K. OTHER INSURANCE

Underwriters shall not pay any claim if there is other insurance which would, or would but for the existence of this insurance, pay such claim. This insurance will apply with respect to expenses is excess of the amount paid or payable under such other insurance. Underwriters shall not pay any claim in respect to care, treatment, services or supplies furnished by any program or agency funded by any government.

L. ASSIGNMENT

The Member may assign benefits under this insurance to a Hospital, Physician or other provider. Any assignment shall not confer upon such Hospital, Physician or other provider, any right or privilege granted to the Member under this insurance except for the right to receive benefits, if any, which are determined to be due and payable hereunder. No Hospital, Physician or other provider shall have any direct or indirect claim or right of action against Underwriters or the Plan Administrator.

M. RIGHT OF RECOVERY

In the event of overpayment of any claim hereunder because:

1. all or some of the expenses were not paid for by or on behalf of the Member or were subsequently recovered by or on behalf of the Member; or
2. any Relative of the Member or any person in the Member's family, whether or not that person is or was a Member, is repaid for all or some of those expenses by a source other than Underwriters; or
3. all or some of the expenses were not Eligible Expenses; or
4. all or some of the expenses were paid or reimbursed based on incorrect benefit application,

Underwriters have the right to recover the amount of overpayment from the Member and/or the Hospital, Physician or other provider of services or supplies. The amount of the recovery is the difference between:

a. the amount of expenses actually paid by Underwriters; and
b. the amount of expenses which should have been paid by Underwriters.

If the Member or the Hospital, Physician or other provider of services or supplies does not promptly make any such refund to Underwriters, Underwriters may, in addition to any other remedies available to them, either:

1. reduce the amount of any future claim that is otherwise eligible for payment hereunder, to the full extent of the refund due Underwriters; or
2. cancel the Certificate issued to the Member by giving 30 days advance written notice by mail to the Member's last known address.

N. CLAIMS ASSISTANCE

Every attempt will be made to help Members understand the benefits provided by this insurance, however, any statement made by an employee of Underwriters or the Plan Administrator will be deemed a representation and not a warranty. Actual benefit payment can only be determined at the time a claim is submitted and all facts are presented in writing. If a definite answer to a specific question is required, the Member can submit a written

request, including all pertinent information and a statement from the attending Physician (if applicable), and a written reply will be sent to the Member and kept on file.

ARTICLE 5 – MEMBER ELIGIBILITY, CERTIFICATE EFFECTIVE DATE, AND CERTIFICATE TERMINATION DATE

A. Eligibility
   1. Only individuals traveling outside of their Home Country who are at least 14 days of age are eligible for coverage under this plan. U.S. citizens must be traveling outside of the U.S. in order to be eligible. For individuals coming to the U.S. who are over age 65, coverage must be effective within 30 days of arrival.

B. Individuals ages 80 and above must select Plan A. Individuals ages 70 to 79 may select Plan A or Plan B. Individuals age 69 and under may select any plan.

C. Certificate Effective Date – Insurance hereunder is effective for a Member on the later of:
   1. the moment Underwriters receive Application and correct premium if Application and payment is made online or by facsimile; or
   2. 12:01 a.m. U.S. Eastern Time on the date Underwriters receive Application and correct premium if Application and payment is made by mail; or
   3. the moment the Member departs from his or her Home Country; or
   4. 12:01 a.m. U.S. Eastern Time on the date requested on the Application.

D. Certificate Termination Date – Insurance hereunder terminates for a Member on the earlier of:
   1. 12:01 a.m. U.S. Eastern Time on the last day of the period for which premium has been paid; or
   2. 12:01 a.m. U.S. Eastern Time on the date requested on the Application; or
   3. the moment of the Member's arrival upon return to his or her Home Country.

Notwithstanding the foregoing, coverage under all Plans shall terminate on the date Underwriters, at their sole option, elect to cancel all Members of the same sex, age, class or geographic location, provided Underwriters give no less than 30 days advance written notice by mail to the Member's last known address.

ARTICLE 6 – SCHEDULE OF BENEFITS AND LIMITS

All benefits, except Emergency Medical Evacuation; Repatriation of Remains; and Common Carrier Accidental Death and Dismemberment, are subject to deductible and are the maximum per certificate period unless stated otherwise.

Penalty for Failure to Pre-Certify: 50% of Eligible Medical Expenses

DEDUCTIBLE (per Injury or Illness)				
	Plan A	**Plan B**	**Plan C**	**Plan D**
Ages 14 days -69 years	$0, $50, or $100			
Age 70 and over	$100 or $200			
Ages 80 and above	$100 or $200			

OVERALL POLICY MAXIMUM				
	Plan A	**Plan B**	**Plan C**	**Plan D**
Ages 14 days - 69 years	$50,000	$75,000	$100,000	$130,000
Ages 70-79	$50,000	$75,000		
Ages 80 and above	$10,000			

INPATIENT TREATMENT				
	Plan A	**Plan B**	**Plan C**	**Plan D**
Hospital Room &Board, including miscellaneous unless specified	$1,450 per day, 30 days max	$1,725 per day, 30 days max	$2,000 per day, 30 days max	$2,585 per day, 30 days max
Intensive Care Unit, including miscellaneous unless specified	$2,110 per day, 8 days max	$2,480 per day, 8 days max	$2,850 per day, 8 days max	$3,690 per day, 8 days max
Surgery	$3,300 per session	$4,400 per session	$5,500 per session	$7,150 per session
Consultant physician	$450	$475	$500	$650
Private duty nurse	$550	$550	$550	$700
Physician visits	$60 per visit, 30 visits max	$75 per visit, 30 visits max	$90 per visit, 30 visits max	$115 per visit, 30 visits max

OUTPATIENT TREATMENT				
	Plan A	**Plan B**	**Plan C**	**Plan D**
Surgery	$3,300 per session	$4,400 per session	$5,500 per session	$7,150 per session
Outpatient Surgical Facility	$1,000	$1,050	$1,100	$1,400
Pre-admission Testing	$1,100	$1,100	$1,100	$1,450
Diagnostic X-ray and Labs	$450, plus $250 for one CAT Scan, MRI or PET	$475, plus $375 for one CAT Scan, MRI or PET	$500, plus $500 for one CAT Scan, MRI or PET	$650, plus $600 for one CAT Scan, MRI or PET

Emergency Room (all expenses incurred therein)	$355	$465	$575	$750
Outpatient Prescription Drugs	$100	$125	$150	$200
Office Visits, including Urgent Care	$60 per visit, 10 visits max	$75 per visit, 10 visits max	$90 per visit, 10 visits max	$115 per visit, 10 visits max

MISCELLANEOUS INPATIENT & OUTPATIENT TREATMENT				
	Plan A	**Plan B**	**Plan C**	**Plan D**
Anesthesiologist	$825	$1,110	$1,375	$1,775
Assistant Surgeon	$825	$1,110	$1,375	$1,775
Local Ambulance	$475	$475	$475	$475
Dental Accident	$550	$550	$550	$550
Physical Therapy	$40 per visit, 1 visit per day, maximum 12 visits			
Durable Medical Equipment	$1,100	$1,200	$1,300	$1,700
Acute Onset of Pre-existing Condition (only available to Members under age 70)	$50,000 Lifetime Maximum for Eligible Medical Expenses	$75,000 Lifetime Maximum for Eligible Medical Expenses	$100,000 Lifetime Maximum for Eligible Medical Expenses	$100,000 Lifetime Maximum for Eligible Medical Expenses
	$25,000 Lifetime Maximum for Emergency Medical Evacuation			

OTHER BENEFITS				
	Plan A	**Plan B**	**Plan C**	**Plan D**
Emergency Medical Evacuation	$50,000 Lifetime Maximum, except as provided under Acute Onset of Pre-existing Condition. Available only to Members under age 70.			
Repatriation of Remains	$7,500 per Member			
Common Carrier Accidental Death & Dismemberment	$25,000 Lifetime Maximum Principal Sum per Member Death or Loss of Two Limbs – Principal Sum Loss of One Limb – One-half the Principal Sum			

ARTICLE 7 – PRE-CERTIFICATION REQUIREMENTS

A. The following expenses must always be Pre-certified:
   1. Inpatient care; and
   2. any Surgery or Surgical Procedure; and
   3. care in an Extended Care Facility; and
   4. Durable Medical Equipment; and
   5. Computerized Tomography (CAT Scan); and
   6. Magnetic Resonance Imaging (MRI).

B. To comply with the Pre-certification requirements, the Member must:

1. Contact the Plan Administrator at the telephone number contained in the Member's Certificate as soon as possible before the expense is to be incurred; and
2. Comply with the instructions of the Plan Administrator and submit any information or documents they require; and
3. Notify all Physicians, Hospitals and other providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Plan Administrator**.**

C. If the Member complies with the Pre-certification requirements, and the expenses are Pre-certified, Underwriters will pay Eligible Medical Expenses subject to all terms, conditions, provisions and exclusions herein. If the Member does not comply with the Pre-certification requirements or if the expenses are not Pre-certified:
1. Eligible Medical Expenses will be reduced by 50%; and
2. The Deductible will be subtracted from the remaining amount; and
3. The benefit will be applied.

D. Emergency Pre-certification: In the event of an Emergency Hospital admission, Pre-certification must be made within 48 hours after the admission, or as soon as is reasonably possible.

E. Pre-certification Does Not Guarantee Benefits – The fact that expenses are Pre-certified does not guarantee either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to all the terms, conditions, provisions and exclusions herein.

F. Concurrent Review – For Inpatient stays of any kind, the Plan Administrator will Pre-certify a limited number of days of confinement. Additional days of Inpatient confinement may later be Pre-certified if a Member receives prior approval.

ARTICLE 8 – ELIGIBLE EXPENSES

A. ELIGIBLE MEDICAL EXPENSES – INPATIENT BENEFITS

Subject to the Deductible and Limits set forth in the ARTICLE 6 – SCHEDULE OF BENEFITS AND LIMITS, Underwriters will pay the following charges made by a Hospital, Physician, Laboratory or other covered medical service provider which are Incurred while the Member is an Inpatient:

1. Hospital room and board expenses including:
    a. Daily room and board and nursing services not to exceed the amount and duration specified in the Schedule of Benefits and Limits; and
    b. Services, supplies, and other hospital miscellaneous which are routinely provided by the Hospital to persons for use while Inpatient; and
    c. Diagnostic testing using radiology, ultrasonic or laboratory services (psychometric, intelligence, competency, behavioral and educational testing are not included); and
    d. Care in an Extended Care Facility following direct transfer from an acute care Hospital, provided such care is recommended by the attending Physician for convalescence related to the Illness or Injury for which the Member was hospitalized as Inpatient. Extended Care Facility benefits accrue toward the limits for Hospital Room and Board.
2. Intensive Care Unit:

a. Daily room and board and nursing services in Intensive Care Unit not to exceed the amount and duration specified in the Schedule of Benefits and Limits; and
b. Services, supplies, and other hospital miscellaneous which are routinely provided by the Hospital to persons for use while Inpatient; and
c. Diagnostic testing using radiology, ultrasonic or laboratory services.

3. Inpatient Surgery: Professional services provided by a Physician, Specialist Physician, and/or surgeon for diagnosis, treatment, and surgery of a covered condition. All covered expenses relating to an Inpatient Surgery, including Physician consultations prior to and after surgery, will be paid under the Inpatient Surgery benefit.
4. Inpatient professional fees for a consultant Physician when the consultant Physician has been requested and approved by the attending Physician.
5. Routine pre-admission testing consisting of major diagnostic procedures, including but not limited to CAT scans, NMR's, and blood chemistries, will be payable under the "Hospital Miscellaneous" benefit.
6. Private duty nursing care while hospitalized as Inpatient, when ordered by a licensed Physician, and if Medically Necessary, but not to include general nursing care provided by the Hospital.
7. Physician visits while the Member is hospitalized as Inpatient, limited to one visit per day and when hospitalization is not related to Surgery.

B. ELIGIBLE MEDICAL EXPENSES – OUTPATIENT BENEFITS

Subject to the Deductible and Limits set forth in the ARTICLE 6 – SCHEDULE OF BENEFITS AND LIMITS, Underwriters will pay the following charges made by a Hospital, Physician, Laboratory or other medical service provider Incurred while the Member is Outpatient:

1. Outpatient Surgery: Professional services provided by a Physician, Specialist Physician, and/or Surgeon for diagnosis, treatment, and surgery of a covered condition. All covered expenses relating to an outpatient Surgery will be paid under the Outpatient Surgery benefit unless otherwise covered by the Outpatient Surgical Facility benefit.
2. Outpatient Surgical Facility: Miscellaneous charges, including operating room, laboratory tests and x-ray exams, professional fees, anesthesia, drugs or medicines (but not for take home drugs), therapeutic services and supplies, when related to an outpatient surgery covered hereunder.
3. Routine pre-admission testing including but not limited to complete blood count, urinalysis, and chest x-ray completed within seven days prior to the date of Hospital admission.
4. Diagnostic testing using radiology, ultrasonic or laboratory services other than such services that are related to a covered outpatient Surgery.
5. Emergency room expenses, including charges for use of the emergency room itself and any supplies or other charges incurred during use of the emergency room for a covered Injury or for a covered Illness resulting in hospitalization as Inpatient.
6. For drugs which require prescription by a Physician for treatment of a covered Injury or Illness, but not for the replacement of lost, stolen, damaged, expired or otherwise compromised drugs, and for a maximum supply of 60 days per prescription.

7. Charges for Physician and Urgent Care Center office visits, including injections administered during visit, for visits not covered under the Outpatient Surgery Benefit.

C. ELIGIBLE MEDICAL EXPENSES – INPATIENT OR OUTPATIENT BENEFITS

Subject to the Deductible and Limits set forth in the ARTICLE 6 – SCHEDULE OF BENEFITS AND LIMITS, Underwriters will pay the following charges made by a Hospital, Physician, Laboratory or other medical service provider Incurred while the Member is Inpatient or Outpatient:

1. Professional services provided by an anesthesiologist and/or assistant surgeon up to 25% each of the Usual, Reasonable and Customary charge of the primary surgeon. Standby availability will not be deemed to be a professional service and therefore will not be covered hereunder.
2. Emergency Local Ambulance transport necessarily incurred in connection with Injury or Illness resulting in Inpatient hospitalization.
3. Emergency Dental Treatment necessary to restore or replace sound natural teeth lost or damaged in an Accident which was covered under this insurance.
4. Medically Necessary rental of Durable Medical Equipment (consisting of a standard basic hospital bed and or a standard basic wheelchair) up to the purchase prices.
5. Physical Therapy if prescribed by a Physician who is not affiliated with the Physical Therapy practice, necessarily incurred to continue recovery from a covered Injury or Illness.

D. ELIGIBLE EXPENSES – EMERGENCY MEDICAL EVACUATION

Subject to the Deductible and Limits set forth in ARTICLE 6 – SCHEDULE OF BENEFITS AND LIMITS, and subject to the Conditions and Restrictions contained in this provision, Underwriters will pay the following expenses arising out of Emergency Medical Evacuation:

1. Emergency air transportation to a suitable airport nearest to the Hospital where the Member will receive treatment; and
2. Emergency ground transportation necessarily preceding Emergency air transportation; and from the destination airport to the Hospital where the Member will receive treatment.

Conditions and Restrictions:

a. The Member must be in compliance with all conditions and provisions of the insurance; and
b. Underwriters will provide Emergency Medical Evacuation benefits only when the Illness or Injury giving rise to the Emergency Medical Evacuation is covered under this Insurance; and
c. Underwriters will provide Emergency Medical Evacuation benefits only when all of the following conditions are met:
    i. Medically Necessary treatment, services and supplies cannot be provided locally; and
    ii. Transportation by any other method would result in loss of Member's life or limb; and
    iii. Recommended by the attending Physician who certifies to the above; and

iv. Agreed upon by the Member or a Relative of the Member; and
v. Approved in advance and coordinated by Underwriters; and
vi. The condition giving rise to the Emergency Medical Evacuation occurred spontaneously and without advance warning, either in the form of Physician recommendation or symptoms which would have caused a prudent person to seek medical attention prior to the onset of the Emergency.

d. Underwriters will provide Emergency Medical Evacuation only to the nearest Hospital that is qualified to provide the Medically Necessary treatment, services and supplies to prevent the Member's loss of life or limb.

e. Underwriters will use their best efforts to arrange any Emergency Medical Evacuation within the least amount of time possible. The Member understands that the timeliness of Emergency Medical Evacuation can be affected by circumstances which are not within the control of Underwriters such as: availability of transportation equipment and staff, delays or restrictions on flights caused by mechanical problems, government officials, telecommunications problems, weather and other acts of God. The Member agrees to hold Underwriters harmless and Underwriters shall not be held liable for any delays that are not within their direct and immediate control.

E. ELIGIBLE EXPENSES – REPATRIATION OF REMAINS

Subject to the Deductible and Limits set forth in ARTICLE 6 – SCHEDULE OF BENEFITS AND LIMITS, and subject to the Conditions and Restrictions contained in this provision, Underwriters will pay the following Repatriation of Remains expenses arising from the death of a Member:

1. Air or ground transportation of bodily remains or ashes to the airport or ground transportation terminal nearest to the Principal Residence of the deceased Member; and
2. Reasonable costs of preparation of the remains necessary for transportation.

Conditions and Restrictions:

a. The Member must be in compliance with all conditions and provisions of this insurance; and

b. Repatriation of Remains must be approved in advance and coordinated by Underwriters; and

c. Underwriters will provide Repatriation of Remains benefits only when the death of the Member occurs as a result of an Injury or Illness that is covered under this insurance; and

d. Underwriters will provide Repatriation of Remains benefits only when the Death of the Member occurs while this insurance is in effect; and

e. Underwriters will use their best efforts to arrange any Repatriation of Remains within the least amount of time possible. The Member understands that the timeliness of Repatriation can be affected by circumstances which are not within the control of Underwriters such as: availability of transportation equipment and staff, delays or restrictions on flights caused by mechanical problems, government officials, telecommunications problems, weather and other acts of God. The Member, and his/her heirs, agrees to hold Underwriters harmless and Underwriters shall not be held liable for any

delays which are not within their direct and immediate control. Further, Underwriters are held harmless and shall not be held liable for loss of or any damage or other impairment to bodily remains incurred during the Repatriation process or otherwise.

F. ELIGIBLE EXPENSES – COMMON CARRIER ACCIDENTAL DEATH & DISMEMBERMENT

Subject to the Limit set forth in ARTICLE 6 – SCHEDULE OF BENEFITS AND LIMITS, and subject to the Conditions and Restrictions contained in this provision, Underwriters will pay the following Common Carrier Accidental Death and Dismemberment benefit:

1. Accidental Death – Underwriters will pay the Principal Sum of $25,000 to the Beneficiary.
2. Accidental Dismemberment –
   a. Loss of 2 or more Limbs or eyes – Underwriters will pay the Principal Sum of $25,000 to the Member.
   b. Loss of 1 Limb or eye – Underwriters will pay $12,500 to the Member.

Conditions and Restrictions:

a. The Member must be in compliance with all conditions and provisions of this insurance; and
b. The Accident giving rise to the Accidental Death or Dismemberment must occur while the Member is a fare paying passenger on a regularly scheduled trip on a Common Carrier; and
c. The maximum benefit is $125,000 any one family and
d. The Accident giving rise to the Accidental Death or Dismemberment must be due solely to Accidental Injury and not contributed to by Illness or disease.

ARTICLE 9 – WAR, TERRORISM, BIOLOGICAL, CHEMICAL, NUCLEAR EXCLUSION

Notwithstanding any provision to the contrary within this insurance or any endorsement or rider attached hereto, it is agreed that this insurance excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss, damage, cost or expense:

1. war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power; and
2. the use of any biological, chemical, radioactive or nuclear agent, material, device or weapon; however, this exclusion shall not apply where the Member is exposed to nuclear radioactive and/or radioactive material for the purpose of medical treatment; and
3. any Act of Terrorism.

For the purpose of this insurance, an "Act of Terrorism" means an act, including but not limited to, the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether

acting alone or on behalf of or in connection with any organization(s) or government(s) committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

This insurance also excludes coverage for loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to (1), (2) or (3) above.

If Underwriters allege that by reason of this exclusion, any loss, damage, cost or expense is not covered by this insurance, the burden of proving the contrary shall be upon the Member.

In the event any portion of this exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

ARTICLE 10 – EXCLUSIONS

Charges for the following treatments, diagnosis, services, supplies, and/or conditions are excluded from coverage hereunder:

1. Routine pre-natal care, Pregnancy, child birth, miscarriage, post natal care or any complication or pregnancy.
2. Charges Incurred by or for any child under the age of 14 days.
3. Diagnosis or treatment related to birth defects and congenital illnesses. Birth defects are deemed to include hereditary conditions.
4. Diagnosis or treatment of Mental Health Disorders, as defined herein.
5. Charges which are not Incurred, as herein defined, by a Member during his/her Certificate Period.
6. Diagnosis or treatment of any condition(s) when the purpose of departing the Home Country was to obtain treatment in the destination country/countries.
7. Charges for any benefit hereunder which are not presented to Underwriters for payment within 60 days beginning on the last day of the Certificate Period.
8. Diagnosis, treatment, services or supplies which are not administered by or under the supervision of a Physician, and products that can be purchased without a doctor's prescription.
9. Diagnosis, treatment, services or supplies which are not Medically Necessary as herein defined.
10. Diagnosis, treatment, services or supplies provided at no cost to the Member.
11. Charges which exceed Usual, Reasonable and Customary as herein defined.
12. Telephone consultations or failure to keep a scheduled appointment.
13. Surgeries, diagnosis, treatments, services or supplies which are Investigational, Experimental or for Research Purposes.
14. All charges Incurred while confined primarily to receive Custodial Care, Educational or Rehabilitative Care, or any medical treatment in any establishment for the care of the aged.
15. Diagnosis or treatment of obesity or weight modification, including wiring of the teeth and all forms of gastrointestinal bypass Surgery.
16. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Member such as sex-change Surgery.

17. Surgeries, diagnosis, treatments, services or supplies for cosmetic or aesthetic reasons, except for reconstructive Surgery when such Surgery is directly related to and follows a Surgery which was covered hereunder.
18. Diagnosis or treatment for HIV, AIDS or ARC, and all diseases caused by and/or related to HIV.
19. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility, sterilization or reversal of sterilization.
20. Any drug, treatment, or procedure that either promotes, enhances or corrects impotency or sexual dysfunction.
21. Willful and/or therapeutic termination of Pregnancy.
22. Dental Treatment, except for Emergency Dental Treatment necessary to replace sound natural teeth lost or damaged in an Accident covered hereunder.
23. Corrective devices and medical appliances, including eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, and any examination or fitting related to these devices, and all vision and hearing tests and examinations.
24. Eye surgery, such as corrective refractory surgery, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
25. Diagnosis or treatment of the temporomandibular joint.
26. Medical expenses for Injury or Illness resulting from participation in organized intercollegiate or interscholastic sports, Professional Sports including practice, aviation (except when traveling solely as a passenger in a commercial aircraft); base jumping; sky surfing; Off-road motorized vehicles including all-terrain vehicles, snowmobiles and motorized dirt bikes, (jet skis excepted) , snow skiing, or snowboarding, except for recreational downhill and/or cross country snow skiing or snowboarding (no coverage provided while skiing away from prepared and marked in-bound territories and/or against the advice of the local ski school or local authoritative body); racing by any animal or motorized vehicle; spelunking; sub aqua pursuits involving underwater breathing apparatus unless PADI/NAUI certified, or accompanied by a certified instructor at depths of less than 10 meters; avalanche training; Aussie rules football; big game hunting; bobsleigh, skeleton, luge, any type of boxing or martial arts, hot air ballooning as a pilot; jousting; modern pentathlon; powerlifting; quad biking outdoor endurance events, speed trials; speedway; wrestling.
27. Injury sustained while under the influence of or due wholly or partly to the effects of intoxicating liquor or drugs other than drugs taken in accordance with treatment prescribed and directed by a Physician except drugs prescribed by a Physician for the treatment of Substance Abuse.
28. Costs resulting from self-inflicted Injury or Illness and/or suicide or attempted suicide whether sane or insane.
29. Diagnosis or treatment of venereal disease, including all Sexually Transmitted Diseases and conditions.
30. Routine medical examinations, including but not limited to vaccinations, immunizations, annual check-ups, the issue of medical certificates and attestations, and examinations as to the suitability of employment or travel.
31. Diagnosis or treatment by a chiropractor.
32. Charges resulting from or occurring during the commission of a violation of law by the Member, including without limitation, the engaging in an illegal occupation or act, but excluding minor traffic violations.

33. Diagnosis or treatment of Substance Abuse or addiction or conditions that may be attributed to Substance Abuse or addictions and direct consequences thereof.
34. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinesitherapy.
35. Psychometric, intelligence, competency, behavioral and educational testing.
36. Any services, diagnosis, supplies, or treatment performed or provided by a Relative of the Member or any family member of the Member or any person who ordinarily resides with the Member.
37. Orthoptics and visual eye training.
38. Diagnosis, treatment or supplies for the feet: orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses or toenails.
39. Diagnostic testing or procedures, services, supplies, and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
40. Pre-existing Conditions. Charges resulting directly or indirectly from any Pre-existing Condition, as herein defined, are excluded from this insurance, except charges resulting directly from an Acute Onset of Pre-existing Condition, as herein defined, are covered for all Members subject to the limits set forth in the Schedule of Benefits and Limits.
41. Exercise programs, whether or not prescribed or recommended by a Physician.
42. Diagnosis or treatment required as a result of complications or consequences of a treatment or condition not covered hereunder.
43. Charges for travel or accommodations, except as provided for in the Local Ambulance, Emergency Medical Evacuation, and Repatriation of Remains sections of this insurance.
44. Diagnosis or treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
45. Organ or Tissue Transplants or related services.
46. Diagnosis or treatment for acne, other acne, moles, skin tags, diseases of sebaceous glands, seborrhea, sebaceous cyst, unspecified disease of sebaceous glands, hypertrophic and atrophic conditions of skin, nevus.
47. Diagnosis or treatment of all forms of cancer / neoplasm.
48. Diagnosis or treatment of sleep apnea or other sleep disorders.
49. All expenses of any cryo preservation and implantation or re-implantation of living cells.
50. All Emergency Medical Evacuation or Repatriation of Remains costs not approved or arranged in advance by Underwriters.
51. Medical conditions while on duty as a member of a police or military force unit.
52. Claims, payable under any government system, including the Australian Medicare system, are excluded from coverage.
53. The Accidental Death & Dismemberment benefit shall be excluded with respect to Accidents occurring while the Member is participating in any of the following:
    a. Amateur Athletics, Contact Sports, intercollegiate, interscholastic, intramural, and club sports or athletic activities and Professional Sports. Non-contact and non-organized/non-sanctioned amateur sports or athletic activities engaged in by the Member solely for leisure, recreational, entertainment or fitness purposes are not excluded unless they are excluded by (b) through (u) of this provision; and
    b. aviation (except when traveling solely as a passenger in a commercial aircraft);
    c. base jumping or bungee jumping;
    d. sky surfing;

e. Off road motorized vehicles including all-terrain vehicles, snowmobiles and motorized dirt bikes, (jet skis excepted) ,
f. snow skiing, or snowboarding, except for recreational downhill and/or cross country snow skiing or snowboarding (no cover provided while skiing away from prepared and marked in-bound territories and/or against the advice of the local ski school or local authoritative body);
g. racing by any animal or motorized vehicle;
h. spelunking;
i. sub aqua pursuits involving underwater breathing apparatus unless PADI/NAUI certified, or accompanied by a certified instructor at depths of less than 10 meters;
j. avalanche training;
k. Aussie rules football;
l. big game hunting;
m. bobsleigh, skeleton or luge ,
n. Any type of boxing or martial arts,
o. hot air ballooning as a pilot;
p. jousting;
q. modern pentathlon;
r. powerlifting;
s. quad biking outdoor endurance events,
t. speed trials; speedway;
u. wrestling

54. Diagnosis, treatment, services, or supplies provided by Home Nursing Care.
55. Expenses incurred within the Member's Home Country
56. Services, diagnosis, supplies, or treatment that are not included as Eligible Expenses as described herein.

ARTICLE 11 – DEFINITIONS

Accident: A sudden, unintentional and unexpected occurrence caused by external, visible means and resulting in physical Injury to the Member.

Accidental Death: A sudden, unintentional and unexpected occurrence caused by external, visible means resulting in physical Injury to the Member and subsequently death of the Member. Death must occur within 30 days of the sudden, unintentional and unexpected occurrence and not be contributed to by Illness or disease.

Accidental Dismemberment: A sudden, unintentional and unexpected occurrence caused by external, visible means and resulting in complete severance from the body of one or more Limbs or eyes and not contributed to by Illness or disease. For purposes of the Common Carrier Accidental Death and Dismemberment benefit provided by this insurance, the term "Limb" shall mean: the arm when the severance is at or above (toward the elbow) the wrist, or the leg when the severance is at or above (toward the knee) the ankle. Loss of eye(s) shall mean: complete, permanent, irrevocable loss of sight.

Acute Onset of Pre-existing Condition: The term "Acute Onset of a Pre-Existing Condition(s)" shall mean a sudden and unexpected outbreak or recurrence of a Pre-existing Condition(s) which occurs spontaneously and without advance warning either in the form of Physician recommendations or symptoms, is of short duration, is rapidly progressive, and requires urgent care. The Acute Onset of a Pre-existing Condition(s) must occur after the effective date of the policy. Treatment must be obtained within 24 hours of the sudden and unexpected outbreak or recurrence.

A Pre-existing Condition that is a chronic or congenital condition or that gradually becomes worse over time will not be considered Acute Onset. This benefit does not include coverage for known, scheduled, required, or expected medical care, drugs or Treatments existent or necessary prior to the Effective Date of coverage.

AIDS: Acquired Immune Deficiency Syndrome as that term is defined by the United States Centers for Disease Control.

ARC: AIDS Related Complex as that term is defined by the United States Centers of Disease Control.

Amateur Athletics: A sport or other athletic activity that is organized and/or sanctioned, involving regular or scheduled practices and/or regular or scheduled games. This definition does not include athletic activities that are non-contact and engaged in by a Member solely for recreational, entertainment or fitness purposes and not for wage, reward or profit.

Application: The fully answered and signed Application which is attached to this Master Policy and the fully answered and signed Application submitted to Underwriters by the Member.

Assured: The Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda.

Beneficiary: The individual named in the Member's Application to be the recipient of any Accidental Death or Common Carrier Accidental Death benefit. For Members who do not designate Beneficiary on the Application, the Beneficiary is automatically as follows:

Members age 18 or older:

1. Spouse (if any),
2. Children (if any) equally,
3. Estate of the Member.

Members under age 18:

1. Custodial Parent(s) (if any),
2. Siblings (if any) equally,
3. Estate of the Member.

Benefits: The Eligible Expenses that will be paid under this Master Policy for covered costs Incurred during the Certificate Period.

Certificate: The document issued to the Member that provides evidence of Benefits payable under this Master Policy and that will confirm the plan type, period of cover, Home Country, certificate number, special terms and/or conditions, Deductible, chosen benefit list, and geographical area of cover.

Certificate Period: The period of time beginning on the date and time of the Certificate Effective Date and ending on date and time of the Certificate Termination Date. The maximum Certificate Period is 364 days.

Common Carrier: An airplane bus, train, or watercraft operating for commercial purposes and carrying fare-paying passengers on regularly scheduled and published routes.

Contact Sports: A sport or other athletic activity that necessarily involves physical contact with opposing players as part of normal play. Contact Sports include but are not limited to American football, boxing, ice hockey, rugby, soccer, and wrestling.

Custodial Care: That type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Member in performing the activities of daily living. Custodial Care also includes non-acute care for the comatose, semi-comatose, paralyzed or mentally incompetent patients.

Declaration: The Declaration is attached to and forms a part of this Master Policy.

Deductible: The dollar amount of Eligible Expenses, specified in the Schedule of Benefits and Limits, that the Member must pay per Injury or Illness per Certificate Period.

Dental Treatment: The care of teeth, gums or bones supporting the teeth, including dentures and preparation for dentures.
Durable Medical Equipment: A standard basic hospital bed and/or a standard basic wheelchair.
Educational or Rehabilitative Care: Care for restoration (by education or training) of one's ability to function in a normal or near normal manner following an Illness or Injury. This type of care includes, but is not limited to, vocational or occupational therapy and speech therapy.
Emergency: A medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Member's life or limb in danger if medical attention is not provided within 24 hours.
Extended Care Facility: An institution, or a distinct part of an institution, which is licensed as a Hospital, Extended Care Facility or rehabilitation facility by the state in which it operates; and is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a Physician and the direct supervision of a Registered Nurse; and maintains a daily record on each patient; and provides each patient with a planned program of observation prescribed by a Physician; and provides each patient with active treatment of an Illness or Injury. Extended Care Facility does not include a facility primarily for rest, the aged, Substance Abuse treatment, Custodial Care, nursing care or for care of Mental Health Disorders or the mentally incompetent.
HIV+: Laboratory evidence defined by the United States Centers for Disease Control as being positive for Human Immunodeficiency Virus infection.
Home Country: For U.S. Citizens, Home Country is the United States of America, regardless of the location of the Member's Principal Residence. For non-U.S. Citizens, Home Country is the country where the Member principally resides and receives regular mail.
Home Health Care Agency: A public or private agency or one of its subdivisions, which operates pursuant to law and is regularly engaged in providing Home Nursing Care under the supervision of a Registered Nurse, and maintains a daily record on each patient, and provides each patient with a planned program of observation and treatment by a Physician.
Home Nursing Care: Services provided by a Home Health Care Agency and supervised by a Registered Nurse, which are directed toward the personal care of a patient, provided always that such care is provided in lieu of Medically Necessary Inpatient care in a Hospital.
Hospital: An institution which operates as a hospital pursuant to law, and is licensed by the State or Country in which it operates; and operates primarily for the reception, care and treatment of sick or injured persons as Inpatients; and provides 24-hour nursing service by Registered Nurses on duty or call; and has a staff of one or more Physicians available at all times; and provides organized facilities and equipment for diagnosis and treatment of acute medical conditions on its premises; and is not primarily a long-term care facility, Extended Care Facility, nursing, rest, Custodial Care or convalescent home, a place for the aged, drug addicts, alcoholics or runaways; or similar establishment.
Illness: A sickness, disorder, illness, pathology, abnormality, ailment, disease or any other medical, physical or health condition. Illness does not include learning disabilities, attitudinal disorders or disciplinary problems.
Incurred: A charge is incurred on the date the service is provided or supply is purchased.
Injury: An unexpected and unforeseen harm to the body caused by an Accident that requires medical treatment.
Inpatient: A patient who occupies a Hospital bed for more than 24 hours for medical treatment and whose admission was recommended by a Physician.
Intensive Care Unit: A Cardiac Care Unit or other unit or area of a Hospital that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Investigational, Experimental or for Research Purposes: Terms used to describe procedures, services or supplies that are by nature or composition, or are used or applied, in a way which deviates from generally accepted standards of current medical practice.

Medically Necessary: A service or supply which is necessary and appropriate for the diagnosis or treatment of an Illness or Injury based on generally accepted current medical practice as determined by Underwriters. A service or supply will not be considered Medically Necessary if it is provided only as a convenience to the Member or provider, and/or is not appropriate for the Member's diagnosis or symptoms, and/or exceeds in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment of an Illness or Injury.

Member: An individual who is covered under this insurance.

Mental Health Disorder: A mental or emotional disease or disorder which generally denotes a disease of the brain with predominant behavioral symptoms; or a disease of the mind or personality, evidenced by abnormal behavior; or a disorder of conduct evidenced by socially deviant behavior. Mental Health Disorders include: psychosis, depression, schizophrenia, bipolar affective disorder, and those psychiatric illnesses listed in the current edition of the diagnostic and Statistical Manual for Mental Disorders of the American Psychiatric Association.

Outpatient: A Member who receives Medically Necessary treatment by a Physician for Injury or Illness that does not require overnight stay in a Hospital.

Physician: A doctor of Medicine (MD), doctor of Dental Surgery (DDS), doctor of Dental Medicine (DDM), doctor of Podiatry (DPM), doctor of Osteopathy (DO), a licensed Physical Therapist or Physiotherapist, and a doctor of Psychiatry (Psy.D) and a doctor of Psychology (Ph.D.). Physician also includes a Certified Nurse Practitioner (CNP), Certified Registered Nurse Anesthetist (CRNA), Nurse Midwife or a Physician Assistant (PA) under the direction of a Medical Doctor. A Physician must be currently licensed by the jurisdiction in which the services are provided, and the services must be within the scope of that license and covered under this Master Policy.

Plan Administrator: HCC Medical Insurance Services, LLC, 251 North Illinois Street, Suite 600, Indianapolis, Indiana 46204, Telephone (317)262-2132, Fax (317)262-2140.

Pre-existing Condition: Any (1) condition for which medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) was recommended or received during the 2 years immediately preceding the Certificate Effective Date; (2) condition that had manifested itself in such a manner that would have caused a reasonably prudent person to seek medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) within the 2 years immediately preceding the Certificate Effective Date; (3) injury, illness, sickness, disease, or other physical, medical, mental, or nervous conditions, disorder or ailment (whether known or unknown) that, with reasonable medical certainty, existed at the time of application or within the 2 years immediately preceding the Certificate Effective Date. For the purposes of the Complications of Pregnancy coverage offered hereunder, Pregnancy will not be included within the definition of a Pre-existing Condition.

Pregnancy: The physical condition of being pregnant.

Professional Sports: An activity undertaken for wage, reward or profit including practice.

Proof of Claim: A completed and signed Claimant's Statement and Authorization form, together with any/all required attachments, original itemized bills from Physicians, Hospitals and other medical providers, original receipts for any expenses which have already been paid by or on behalf of the Member, and any other documentation that is deemed necessary by the Underwriters.

Registered Nurse: A graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "RN" after his or her name.
Relative: Biological or step parent; biological or step child; current spouse; biological or stepsiblings; or parent, children, or sibling in law.
Routine Physical Exam: Examination of the physical body by a Physician for preventative or informative purposes only, and not for the diagnosis or treatment of any condition.
Sexually Transmitted Diseases: Syphilis, gonorrhea, lymphogranuloma venereum, chancroid, granuloma inguinale, chlamydiosis, trichomoniasis, genital candidiasis, genital herpes, Pelvic Inflammatory Disease (PID), Human Papillomavirus (HPV), mycoplasma genitalium, and viral hepatitis.
Specialist Physician: A doctor of medicine (MD) who has completed the training for and has become certified in a specialty or sub-specialty of the medical arts. Specialist Physician does not include a Doctor of Chiropractic (DC), a Doctor of Psychiatry (PsyD) or Doctor of Psychology (PhD). A Physician must be currently licensed by the jurisdiction in which the services are provided, and the services must be within the scope of that license.
Substance Abuse: Alcohol, drug or chemical abuse, overuse or dependency.
Surgery or Surgical Procedure: 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.
Treatment: Care, including but not limited to consultation, diagnostic testing, drug prescription, evaluation, examination, and therapy, involving the administration of medical management for an Injury or Illness.
Urgent Care Center: A U.S. medical facility separate from a hospital emergency department where ambulatory patients can be treated on a walk-in basis without an appointment and receive immediate, non-routine urgent care for an Injury or Illness presented on an episodic basis.
U.S.: The United States of America including all states, districts, territories and possessions.
Usual, Reasonable and Customary: The most common charge for similar services, medicines or supplies within the area in which the charge is incurred, so long as those charges are Reasonable. What is defined as Usual, Reasonable and Customary Charges will be determined by Underwriters. In determining whether a charge is Usual, Reasonable and Customary, Underwriters may consider one or more of the following factors: the level of skill, extent of training, and experience required to perform the procedure or service; the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services; the severity or nature of the Illness or Injury being treated; the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country; the cost to the provider of providing the service, medicine or supply; such other factors as Underwriters, in the reasonable exercise of discretion, determine are appropriate.

ARTICLE 12 – HOW TO FILE A CLAIM

Notice of Claim, Claimant's Statement and Authorization, and Proof of Claim must be mailed to:
HCC Medical Insurance Services, LLC
Box No. 2005
Farmington Hills, MI 48333-2005