



# Travel Accident Plan

Plan Document and  
Summary Plan Description



# STARR

## INSURANCE COMPANIES

Dallas, Texas

Administrative Office: 399 Park Avenue, 8<sup>th</sup> Floor, New York, NY 10022

### BLANKET BUSINESS TRAVEL INSURANCE POLICY

**POLICYHOLDER:** St. John's University

**POLICY NUMBER:** BTAI 273736

**POLICY EFFECTIVE DATE:** June 1, 2023

**POLICY ANNIVERSARY DATE:** June 1

**POLICY TERM:** June 1, 2023 through June 1, 2026

The Policy takes effect at 12:01 A.M. on the Policy Effective Date shown above. It will remain in effect for the duration of the Policy Term shown above if the premium is paid according to the agreed terms. The Policy terminates at 12:00 A.M., on the last day of the Policy Term and unless the Policyholder and We agree to continue coverage under the Policy for an additional Policy Term. If coverage is continued for an additional Policy Term and the required premiums are paid on or before the Premium Due Date, We will issue a rider to identify the new Policy Term.

The Policy is governed by the laws of the State of New York.

Signed for Starr Indemnity & Liability Company By:



Nehemiah E. Ginsburg  
General Counsel and Secretary



Steve Blakey  
President and Chief Executive Officer

**THIS IS A BLANKET ACCIDENT AND SICKNESS INSURANCE POLICY.**

**THE POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM SICKNESS DURING THE HAZARDS SHOWN IN THE SCHEDULE OF BENEFITS WHILE TRAVELING OUTSIDE OF THE UNITED STATES.**

**THIS IS A LIMITED POLICY.  
PLEASE READ THE POLICY CAREFULLY.**

This Policy does NOT provide Major Medical insurance as defined by the New York Insurance Department. The anticipated loss ratio for this Policy is 65%. This ratio is the portion of future premiums which the Company expects to return as benefits when averaged over all people with this Policy.

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**SECTION 1: SCHEDULE OF BENEFITS**

**POLICYHOLDER:** St. John's University

**POLICY NUMBER:** BTAI 273736

**POLICY EFFECTIVE DATE:** June 1, 2023

**POLICY ANNIVERSARY DATE:** June 1

**POLICY TERM:** June 1, 2023 through June 1, 2024

**PREMIUM DUE DATE:** Annually in advance on Anniversary Date

**AGGREGATE LIMIT:**

Benefit Maximum: \$10,000,000

We will not pay more than the Benefit Maximum for all losses per Covered Accident. If, in the absence of this provision, We would pay more than Benefit Maximum for all losses from one Covered Accident, then the benefits payable to each person with a valid claim will be reduced proportionately, so the total amount We will pay is the Benefit Maximum.

**CLASSES OF ELIGIBLE PERSONS:**

Class 1: The President of the Policyholder.

Class 2: All Employees in the following named positions and the direct reports to the President Men's Basketball Head Coach

Class 3: All Other Executive Management Employees who are on file with the Policyholder.

Class 4: All Other Full-Time Employees of the Policyholder.

Class 5: All Spouses/Domestic Partners of Class 1, 2, 3 and 4.

Class 6: All Dependent Children of Class 1,2,3 and 4.

**HAZARDS INSURED AGAINST:**

Class 1 and 2: 24 Hour Business and Pleasure

Class 3 and 4: 24 Hour Business Only

Class 5 and 6: Family Accompany and Relocation

## **DESCRIPTION OF BENEFITS**

### **ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS**

Principal Sum: Class 1: \$7,000,000  
Class 2: \$1,000,000  
Class 3: \$500,000  
Class 4: \$100,000  
Class 5: \$50,000  
Class 6: \$25,000

Time Period for Loss from date of Accident: 365 days

Covered Losses: See Benefit

### **MEDICAL EXPENSE BENEFITS**

Total Maximum for all Medical Expense Benefits:

Deductible: \$250,000

Co-insurance Rate: 100% of all Covered Expenses

Maximum Benefit Period: 1 year  
from the date of the Covered Accident or Sickness

Emergency Medical Evacuation Benefit

Benefit Maximum: Actual Cost

Deductible: \$0

Repatriation of Remains Benefit

Benefit Maximum: Actual Cost

Deductible: \$0

### **ADDITIONAL BENEFITS**

Bereavement and Trauma Counseling Benefit:

Benefit Amount Per Session: \$150

Maximum Number of Sessions: 10

Maximum Benefit Amount: \$1,500

Daycare Benefit:

10% of the Principal Sum up to a maximum of \$10,000

Seatbelt and Airbag Benefit:

Full Seatbelt Benefit: 10% of Principal Sum to max of \$25,000

Airbag Benefit: 5% of Principal Sum to max of \$25,000

Default Benefit: \$2,000

Felonious Assault Benefit:

10 % of Principal Sum

Home Alteration And Vehicle Modification Benefit:

20% of the Principal Sum up to a maximum of \$50,000

## INITIAL PREMIUM RATES:

Three Year Annual Installment:	June 1, 2023 – June 1, 2024	\$10,000
	June 1, 2024 – June 1, 2025	\$10,000
	June 1, 2025 – June 1, 2026	\$10,000

## SECTION 2: DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

**“Accident”** means a sudden, unexpected and unintended event.

**“Active Service”** means a Covered Person is either 1) actively at work performing all the regular duties on a full-time basis either at his or her employer’s place of business or some place the employer requires him or her to be; or 2) if not employed, able to engage in substantially all of the usual activities of a person in good health of like age and sex and not confined in a Hospital or rehabilitation or rest facility.

**“Covered Accident”** means an Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Policy for which benefits are payable.

**“Covered Activity”** means any activity that the Policyholder requires the Covered Person to attend, or that is under its supervision and control listed in the Schedule of Benefits and insured under the Policy.

**“Covered Expenses”** means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies covered by the Policy. Coverage under the Policyholder’s Policy must remain continuously in force from the date of the Accident or Sickness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

**“Covered Loss” or “Covered Losses”** means an accidental death, dismemberment or other Injury covered under the Policy.

**“Covered Person”** means any Insured and Dependent for whom the required premium is paid.

**“Deductible”** means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person on a per Injury, Accident, Policy Term or Sickness basis before Medical Expense Benefits and/or other Additional Benefits paid on an expense incurred basis are payable under the Policy.

**“Dependent”** means an Insured’s:

1. lawful spouse ; and
2. unmarried natural children, newborn children, stepchildren, legally adopted children, children in the process of adoption, foster children; court-ordered children or any other children related to the Insured by blood or marriage;

provided such children are less than the Limiting Age of 29 years, are not eligible for employer sponsored health insurance and are not covered by Medicare.

The Limiting Age shall not so terminate with respect to an unmarried child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap and who became so incapable prior to attainment of the age at which Dependent coverage would otherwise terminate. Such child must be chiefly dependent upon the Insured for support and maintenance. The Insured must within 31 days of such Dependent's attainment of the termination age submit proof of such Dependent's incapacity as described herein.

If the Insured marries while covered under the Policy, their spouse shall automatically become covered under the Policy.

If, while covered under the Policy, the Insured:

1. has a newborn child; or
  2. adopts or receives a foster or stepchild;
- the child will become covered under the Policy from the date of birth or the date of financial dependence on the Insured or the beginning of any waiting period prior to finalization of the child's adoption, if earlier. Benefits and amounts will be the same as those We are providing for Dependent children under the Policy at that time.

Newly born infants adopted by the Insured shall covered from the moment of birth if the Insured takes physical custody of the infant upon such infant's release from the Hospital and files a petition pursuant to section 115-c of the domestic relations law within 30 days of birth, unless consent to the adoption has been revoked.

**“Doctor”** means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a Covered Person that is appropriate for the conditions and locality. It will not include a Covered Person or a member of the Covered Person's Immediate Family Member or household.

**“Health Care Plan”** means a policy or other benefit or service arrangement for medical or dental care or treatment under: 1) group or blanket coverage, whether on an insured or self-funded basis; 2) hospital or medical service organizations on a group basis; 3) Health Maintenance Organizations on a group basis; 4) group labor-management plans; 5) employee benefit organization plans; 6) association plans on a group or franchise basis; or 7) any other group employee welfare benefit plan as defined in the employee Retirement income Security Act of 1974, as amended.

**“Home Country”** means a country from which the Covered Person holds a passport. If the Covered Person holds passports from more than one country, his or her Home Country will be that country which the Covered Person has declared to Us in writing as his or her Home Country.

**“Hospital”** means a facility that: (1) is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons; (2) has organized departments of medicine and major surgery; (3) has a requirement that every patient must be under the care of a Physician or dentist; (4) provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.); (5) has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97, (42 USCA 1395xk); (6) is duly licensed by the agency responsible for licensing such hospitals. A Hospital does not include a facility or a section of a facility, that is, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

**“Hospital Confined”** means a stay of 24 or more consecutive hours as a registered resident bed-patient in a Hospital.

**“Immediate Family Member”** means a person who is related to the Covered Person in any of following ways: spouse; parent (includes stepparent); child age 18 or older (includes legally adopted and step child); brother or sister (includes stepbrother or stepsister); parent-in-law; son or daughter-in-law; and brother- or sister-in-law.

**“Injury”** means accidental bodily harm sustained by a Covered Person that results directly and independently from all other causes from a Covered Accident. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

**“Insured”** means a person in a Class of Eligible Persons for whom the required premium is paid making insurance in effect for that person. A Dependent covered under the Policy is not an Insured, but rather a Covered Person.

**“Medical Emergency”** means a condition caused by an Injury or Sickness that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

**“Medically Necessary”** means a treatment, service or supply that is: 1) required to treat an Injury or Sickness; prescribed or ordered by a Doctor or furnished by a Hospital; 2) performed in the least costly setting required by the Covered Person’s condition; and 3) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. Purchasing or renting 1) air conditioners; 2) air purifiers; 3) motorized transportation equipment; 4) escalators or elevators in private homes; 5) eye glass frames or lenses; 6) hearing aids; 7) swimming pools or supplies for them; and 8) general exercise equipment are not considered Medically Necessary. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of the alternative to be the Covered Expense.

**“Other Income Benefits”** means any amounts that an Insured or an Insured’s dependents receives (or are assumed to receive) under:

1. any Workers’ Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted. If paid as a lump sum, We will prorate these benefits over the period for which the sum is given. If no time is stated, the lump sum will be prorated over a five year period. If no specific allocation of a lump sum is made, then the total sum will be an Other Income Benefit.
2. any Social Security or retirement benefits the Covered Person receive or any third party receives (or is assumed to receive) on the Insured’s behalf or for the Insured’s dependents; or, if applicable, that the Insured Dependents receive (or are assumed to receive) because of the Covered Person’s entitlement to such benefits.
3. Any proceeds payable under any group insurance or similar plan. If there is other insurance that applies to the same claim for disability, and contains the same or similar provision for reduction because of other insurance, We will pay our pro rata share of the total claim. “Pro rata share” means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.



“**Sickness**” means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

“**Trip**” means travel by air, land, or sea from the Covered Person’s Home Country.

“**Usual and Customary Charge**” means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

“**We**”, “**Our**”, “**Us**” means Starr Indemnity & Liability Company or its authorized agent.

### **SECTION 3: ELIGIBILITY FOR INSURANCE**

Each person in one of the Classes of Eligible Persons shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date. We maintain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

An Insured’s Dependent is eligible on the date:

1. the Insured is eligible, if the Insured has Dependents on that date; or
2. the date the person becomes a Dependent, if later.

In no event will a dependent be eligible if the Insured is not eligible.

### **SECTION 4: EFFECTIVE DATE OF INSURANCE**

An Eligible Person will be insured on the latest of the following dates:

1. the Policy Effective Date; or
2. the date he or she is eligible; or
3. the date of the scheduled Trip departure date; or
4. the date of his or her departure from the United States.

### **SECTION 5: TERMINATION DATE OF INSURANCE**

An Insured’s coverage will end on the earlier of the date:

1. the policy terminates;
2. the Insured is no longer eligible;
3. the period ends for which premium is paid;

A Dependent’s coverage will end on the earliest of the date:

1. he or she is no longer a Dependent;
2. the Insured’s coverage ends;
3. the period ends for which premium is paid;

## EXTENSION OF BENEFITS

We will extend benefits under the Policy for 3 months after a Covered Person's coverage would otherwise end if on that date he or she is:

1. Hospital Confined for an Injury or Sickness covered by the Policy; and
2. under a Doctor's care.

Any benefits payable under this provision will not exceed the benefit maximums shown in the Schedule of Benefits.

## SECTION 6: DESCRIPTION OF BENEFITS

The following Provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits on a class level.

### A. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

If Injury to the Covered Person results, within the Time Period for Loss from date of Accident shown in the Schedule of Benefits, in any one of the losses shown below, We will pay the Benefit Amount shown below for that loss. The Principal Sum is shown in the Schedule of Benefits. If multiple losses occur, only one Benefit Amount, the largest, will be paid for all losses due to the same Accident.

<b>Covered Loss</b>	<b>Benefit Amount</b>
Life .....	100% of the Principal Sum
Quadriplegia.....	100% of the Principal Sum
Two or more Members.....	100% of the Principal Sum
One Member .....	50% of the Principal Sum
Hemiplegia .....	50% of the Principal Sum
Paraplegia.....	75% of the Principal Sum
Uniplegia.....	25% of the Principal Sum
Thumb and Index Finger of the Same Hand.....	25% of the Principal Sum

“Quadriplegia” means total Paralysis of both upper and lower limbs. “Hemiplegia” means total Paralysis of the upper and lower limbs on one side of the body. “Uniplegia” means total Paralysis of one lower limb or one upper limb. “Paraplegia” means total Paralysis of both lower limbs or both upper limbs. “Paralysis” means total loss of use. A Doctor must determine the loss of use to be complete and not reversible at the time the claim is submitted.

“Member” means Loss of Hand or Foot, Loss of Sight, Loss of Speech, and Loss of Hearing. “Loss of Hand or Foot” means complete Severance through or above the wrist or ankle joint. “Loss of Sight” means the total, permanent Loss of Sight of one eye. “Loss of Speech” means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. “Loss of Hearing” means total and permanent Loss of Hearing in both ears that is irrecoverable and cannot be corrected by any means. “Loss of a Thumb and Index Finger of the Same Hand” or “Loss of Four Fingers of the Same Hand” means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). “Severance” means the complete separation and dismemberment of the part from the body.

## **B. MEDICAL EXPENSE BENEFITS**

We will pay Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident or Sickness. These benefits are subject to the Deductibles, Coinsurance Rates, Benefit Periods, Benefit Maximums and other terms or limits shown in the Schedule of Benefits.

Medical Expense Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Covered Medical Expenses that the Covered Person receives; and
3. when the first charges are incurred within 90 days after the date of the Covered Accident or Sickness.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

### **Covered Medical Expenses**

1. Hospital Room and Board Expenses: the daily room rate when a Covered Person is Hospital Confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
2. Ancillary Hospital Expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when Hospital Confined. This does not include personal services of a non-medical nature.
3. Daily Intensive Care Unit Expenses: the daily room rate when a Covered Person is Hospital Confined in a bed in the Intensive Care Unit and nursing services other than private duty nursing services.
4. Medical Emergency Care (room and supplies) Expenses: incurred within 72 hours of an Accident and including the attending Doctor's charges, X-rays, laboratory procedures, use of the emergency room and supplies.
5. Newborn Nursery Care Expenses.
6. Outpatient Surgical Room and Supply Expenses for use of the surgical facility.
7. Outpatient diagnostic X-rays, laboratory procedures and tests.
8. Doctor Non-Surgical Treatment/Examination Expenses (excluding medicines) including the Doctor's initial visit, each Medically Necessary follow-up visit and consultation visits when referred by the attending Doctor.
9. Doctor's Surgical Expenses If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session but through different incisions, We will pay as shown in the Schedule of Benefits for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.
10. Assistant Surgeon Expenses when Medically Necessary
11. Anesthesiologist Expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
12. Outpatient Laboratory Test Expenses.
13. X-ray Expenses (including reading charges) but not for dental X-rays.
14. Dental Expenses including dental x-rays for the repair or treatment of each injured tooth that is whole, sound and a natural tooth at the time of the Accident ,and emergency alleviation of dental pain.

15. Dental Expenses for impacted wisdom tooth.
16. Outpatient Registered Nurse Services if ordered by a Doctor.
17. Ambulance Expenses for transportation from the emergency site to the Hospital.
18. Rehabilitative braces or appliances prescribed by a Doctor. It must be durable medical equipment that 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of the purchase price.
19. Prescription Drug Expenses including dressings, drugs and medicines prescribed by a Doctor and administered on an outpatient basis.
20. Medical Equipment Rental Expenses for a wheelchair or other medical equipment that has therapeutic value for a Covered Person. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids.
21. Medical Services and Supplies: expenses for blood and blood transfusions; oxygen and its administration.
22. Eyeglasses, contact lenses and hearing aids when damage occurs in a Covered Accident that requires medical treatment.
23. Emergency medical treatment of pregnancy.
24. Therapeutic termination of pregnancy.

Under New York law, certain mandated benefits are required for coverage. We will also cover all Medically Necessary mandated coverages pursuant to New York law, subject to the same terms and conditions.

## **C. ADDITIONAL BENEFITS**

### **Bereavement and Trauma Counseling Benefit**

We will pay for counseling sessions, up to the Maximum Benefit Amount shown in the Schedule of Benefits and subject to the following conditions, when the Covered Person and/or Immediate Family Member requires bereavement and trauma counseling because the Covered Person suffered a Covered Loss that resulted directly and independently of all other causes from a Covered Accident. Such counseling must meet all of the following conditions:

1. covered bereavement and trauma counseling expenses must be incurred within 1 year from the date of the Covered Accident causing the Covered Loss;
2. the expense is charged for a bereavement or trauma counseling session for the Covered Person and/or one or more of his or her Immediate Family Members;
3. counseling is provided under the care, supervision or order of a Doctor;
4. a charge would have been made if no insurance existed.

"Immediate Family Member" means a person who is related to the Covered Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister) or child (includes legally adopted child or stepchild), grandchild and grandparent.

### **Daycare Benefit**

If the Insured sustains an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Day Care Benefit as shown in the Schedule of Benefits for each of the Insured's Dependent children if such Dependent child is under age 13 at the time of the Insured's death.

This benefit will be paid after We receive proof of enrollment in a Day Care Program as described in this Benefit.

We will make 4 Day Care Benefit payment each year, for a maximum of 4 Day Care Benefit payments, for each Dependent Child. The Benefit will be paid to the person who has primary responsibility for the Dependent Child's Day Care expenses.

Proof of enrollment satisfactory to Us for each Dependent Child in a Day Care Program includes, but will not be limited to, the following:

1. a copy of the Dependent Child's approved enrollment application in a Day Care Program;
2. cancelled checks(s) evidencing payment to a Day Care facility or Day Care provider;
3. a letter from the Day Care facility or Day Care provider stating that the Dependent Child:
  - a. is attending a Day Care Program; or
  - b. has been enrolled in a Day Care Program and will be attending within 90 days of the date of the death.

We will pay the Alternate Amount for this Benefit if no person qualifies as a Dependent Child under this Benefit.

### **Emergency Medical Evacuation Benefit - 100 Miles**

We will pay Emergency Medical Evacuation Benefits as shown in the Schedule of Benefits for expenses incurred for the medical evacuation of a Covered Person. Benefits are payable if the Covered Person:

1. is traveling 100 miles or more away from his or her Place of Permanent Residence;
2. suffers an Injury or Sickness during the course of the Trip; and
3. requires Emergency Medical Evacuation.

Benefits will not be payable unless:

1. the Doctor ordering the Emergency Medical Evacuation certifies the severity of the Covered Person's Injury or Sickness requires an Emergency Medical Evacuation;
2. all transportation arrangements made for the Emergency Medical Evacuation are by the most direct and economical conveyance and route possible;
3. the charges incurred are Medically Necessary and do not exceed the usual level of charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and
4. do not include charges that would not have been made if there were no insurance.

"Emergency Medical Evacuation" means:

1. the Covered Person's immediate transportation from the place where he or she suffers an Injury or Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained; or
2. the Covered Person's transportation to his or her Home Country to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Sickness.

An Emergency Medical Evacuation also includes Medically Necessary medical treatment, medical services and medical supplies necessarily received in connection with such transportation.

Benefits will not be payable unless We authorize in writing or by an authorized electronic or telephonic means all expenses in advance.

### **Home Alteration and Vehicle Modification Benefit**

We will pay the Home Alteration and Vehicle Modification Benefits shown in the Schedule of Benefits, subject to the following conditions, when the Covered Person suffers a Covered Loss,

other than a Loss of Life, resulting directly and independently of all other causes from a Covered Accident.

This benefit will be payable if all of the following conditions are met:

1. prior to the date of the Covered Accident causing such Covered Loss, the Covered Person did not require the use of any adaptive devices or adaptation of residence and/or vehicle;
2. as a direct result of such Covered Loss, the Covered Person now requires such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle;
3. the Covered Person requires home alteration or vehicle modification within 2 years of the date of the Covered Accident.

#### **Repatriation of Remains Benefit – 100 Miles**

We will pay Repatriation of Remains Benefits as shown in the Schedule of Benefits for return of a Covered Person's body to his or her Place of Permanent Residence if he or she dies due to an Injury or Sickness while traveling 100 miles or more away from his or her Place of Permanent Residence. Covered expenses include transporting the remains by the most direct and least costly conveyance and route possible.

Benefits will not be payable unless We authorize in writing or by an authorized electronic or telephonic means all expenses in advance.

#### **Seatbelt And Airbag Benefit**

We will pay benefits shown in the Schedule of Benefits, subject to the conditions described below, when a Covered Person dies or is dismembered directly and independently from Injuries sustained while wearing a seatbelt and operating or riding as a passenger in an Automobile. An additional benefit is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

Verification of proper use of the seatbelt at the time of the Covered Accident and that the Supplemental Restraint System properly inflated upon impact must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Covered Person's claim to Us.

If such certification or police report is not available or it is unclear whether the Covered Person was wearing a seatbelt [or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System], We will pay a default benefit shown in the Schedule of Benefits to the Insured if living, if not, then to the Covered Person's beneficiary.

In the case of a child, "seatbelt" means a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration, properly secured and being used as recommended by its manufacturer for children of like age and weight at the time of the Covered Accident.

"Supplemental Restraint System" means an airbag that inflates upon impact for added protection to the head and chest areas.

"Automobile" means a self-propelled, private passenger motor vehicle with four or more wheels that is a type both designed and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, sport utility vehicle, or a motor vehicle of the pickup, van, camper, or motor-home type. Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

**Felonious Assault Benefit**

We will pay the Felonious Assault Benefit shown in the Schedule of Benefits if, while a Covered Person is traveling, he or she is the victim of a Felonious Assault, and as the result of the assault he or she suffers a covered Injury. A person other than another person covered by the Policy, a Covered Person's Family Member or household member must inflict the assault.

"Felonious Assault" means an act of physical violence against a person covered by the Policy.

"Family Member" means a Covered Person's parent, sister, brother, husband, wife or children

**SECTION 7: HAZARDS INSURED AGAINST**

We will pay benefits described in the Policy when a Covered Person suffers a loss or Injury as a result of a Covered Accident or Sickness during one of the Covered Activities listed in the Schedule of Benefits. We will only pay benefits if the Insured is engaged in one of the hazards described below when the Covered Accident or Sickness occurs. Unless otherwise specified, We will pay benefits only once for any one Covered Accident or Sickness, even if it is covered by more than one hazard.

**Business Travel Coverage (24 Hour Coverage)**

The Covered Accident or Sickness must take place while:

1. traveling or making a short stay of twelve or less; and
2. on business for the Policyholder; and
3. in the course of the Policyholder's business.

This coverage will start at the actual start of the business trip. It does not matter whether the trip starts at the Covered Person's home, place of work, or other place. It will end on the first of the following dates to occur:

1. the date a Covered Person returns to his or her home;
2. the date a Covered Person returns to his or her place of work; or
3. the date a Covered Person makes a Personal Deviation.

"Personal Deviation" means:

1. an activity that is not reasonably related to the Policyholder's business/activities; and
2. not incidental to the purpose of the business trip.

**Exposure and Disappearance**

Coverage under this Hazard includes exposure to the elements after the forced landing, stranding, sinking, or wrecking of a vehicle in which the Covered Person was traveling.

A Covered Person is presumed dead if:

1. he or she is in a vehicle that disappears, sinks or is stranded or wrecked on a trip covered by the Policy; and
2. the body is not found within one year of the Covered Accident.

**Family Accompanying the Insured Coverage**

The Covered Accident must take place while a Covered Person's Dependent:

1. is accompanying the Insured or on his or her way to join the Insured; and
2. when the trip is authorized by and/or paid for in whole or in part by the Policyholder; and

3. while the Insured is covered during the course of the coverage described in the Policy.

### **Family Relocation Trip Coverage**

The Covered Accident of an Insured's Dependent must take place during the course of the Family Relocation Trip.

"Family Relocation Trip" means a trip made by an Insured's Dependent in connection with the Insured's transfer or proposed transfer by the Policyholder to a new worksite. Such trip must be authorized by, or taken at the direction of, the Policyholder and/or must be paid for in whole or in part by the Policyholder.

### **24 Hour Coverage**

We will pay the benefits described in the Policy when a Covered Person suffers a Covered Loss from a Covered Accident any time while insured by the Policy. Unless otherwise specified, We will pay benefits only once for a Covered Loss.

## **SECTION 8: SCOPE OF COVERAGE**

All Benefits provided under the Policy will be paid on a Primary basis without regard to any Coordination of Benefits provisions in any other plan.

The following Coordination of Benefits provision only applies to the MEDICAL EXPENSE BENEFITS:

### **COORDINATION OF BENEFITS**

This section will be used to determine the Covered Person's benefits under this Policy IF:

- the person for whom claim is made is insured for medical care benefits under this Policy and is also covered for these benefits under other Plans,

and

- the benefits that would be paid by this Policy, without this section

PLUS

- the benefits that would be paid by the other Plans, without a section similar to this section WOULD EXCEED ALLOWED EXPENSES as defined below.

### **DEFINITIONS**

PLAN means a plan, which provides benefits or services for, or by reason of, hospital, surgical, medical, or dental care or treatment through:

1. group or blanket insurance coverage; this does not apply to blanket school accident only coverages;
2. pre-paid plans for:
  - group hospital service;
  - group medical service;



- group practice;
  - individual practice; and
  - any other such plans for members of a group;
3. any plan provided by:
    - labor management trusts;
    - unions;
    - employer organizations;
    - professional organization; or
    - employee benefit organizations;
  4. a government program, or statute, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;
  5. Medicare (Title XVIII of the Social Security Act); and
  6. any part of a state auto reparation or indemnity act (no fault insurance) with which the state permits coordination.

Plan does not include individual or family policies, subscriber contracts, or coverage through health maintenance organizations (HMOs). It does not include individual or family coverage under other prepayment, or group practice and individual practice plans. Plan shall not include a state plan under Medicaid, nor will it include a law or plan when by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.

THIS PLAN means the medical care benefits provided by this Policy.

ALLOWED EXPENSE means an expense, which is:

- any necessary, Usual and Customary Charge;
- incurred while the person (for whom the claim is made) is insured, or is entitled to benefits after insurance ends, under this Policy; and
- at least partly covered under one of the plans covering such person.

When this plan does not pay its benefits first, "Allowed Expense" will not include an expense, which is not paid because of the claimant's failure to comply with the cost containment requirements of the plan, which pays its benefits first.

When a plan provides a benefit as a service rather than a cash payment, the reasonable cash value of the service will be considered to be both an Allowed Expense and a benefit paid.

#### EFFECT ON BENEFITS UNDER THIS PLAN

When this section is used, the rules listed below will determine the amount of benefit each plan will pay. All benefits will be determined on a calendar year basis.

These rules may require this plan to pay its benefits first. If so, this plan will pay its full benefits without taking into account other plan benefits. These rules may require one or more of the other plans to pay their benefits before this plan. If so, this plan will reduce its benefits so that in any calendar year, the sum of all benefits to be paid to a person (by this and all other plans) equals the Allowed Expenses for that year. Benefits to be paid under other plans include benefits that would be paid if proper claim is made for such benefits.

#### RULES TO DETERMINE WHICH PLAN PAYS FIRST

- (1) The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist. A secondary plan may take the benefits of another plan into account only when, under these rules, it is secondary to that other plan.

(2) When there is a basis for a claim under more than one plan, a plan with a coordination of benefits provision complying with this section is a secondary plan which has its benefits determined after those of the other plan, unless the other plan has a COB provision complying with this section in which event the order of benefit determination rules will apply.

(3) The order of benefit payments is determined using the first of the following rules which applies:

(i) the benefits of a plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of a plan which covers the person as a dependent;

(ii) except as stated in subparagraph (iii) of this paragraph, when a plan and another plan cover the same child as a dependent of different persons, called parents:

(a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;

(c) if the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;

(d) the word birthday refers only to month and day in a calendar year, not the year in which the person was born;

(iii) if two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) first, the plan of the parent with custody of the child;

(b) then, the plan of the spouse of the parent with custody of the child;

(c) finally, the plan of the parent not having custody of the child; and

(d) if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge;

(iv) the benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this subparagraph is ignored;

(v) if none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

(a) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new plan does not include:

(1) a change in the amount or scope of a plan's benefits;

(2) a change in the entity which pays, provides or administers the plan's benefits; or

(3) a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(b) The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force

If the benefits of this plan are reduced due to these rules, such reduction will be done in proportion. Any benefits paid by this plan on a reduced basis will be charged against the benefit limits of this plan.

#### RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For this section to work, We must exchange information with other plans. To do so, We may give to, or get from any source all such information necessary. This will be done without the consent of or notice to any person. Any person claiming benefits under this plan must give to Us the required information.

#### FACILITY OF PAYMENT

Another plan may pay a benefit that should be paid by Us by terms of this section. If this happens, We may pay to such payor the amount required for it to satisfy the intent of this section. This will be done at Our discretion. Any amount so paid will be considered a benefit under this plan. We will not be liable for such payment after it is made.

#### RIGHT OF RECOVERY

If We pay an amount that is more than should have been paid under this Coordination of Benefits provision, We may recover the excess from one or more of the following:

- (a) the persons We have paid or for whom it has paid;
- (b) insurance companies; or
- (c) other organizations.

## SECTION 9: EXCLUSIONS

We will not pay benefits for any Accidental Death and Dismemberment loss or Injury that is caused by, or results from:

1. suicide, attempted suicide or intentionally self-inflicted injury;
2. war or act of war, whether declared or undeclared. However this does not apply to terrorism.
3. any condition for which the Covered Person is paid benefits under any state or Federal workers' compensation, employers' liability or occupational disease law;
4. the Covered Person's active participation in a riot or insurrection;
5. Injury to which a contributing cause was the Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation;
6. Injury sustained or contracted in consequence of the Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of a Doctor.
7. mental or emotional disorders, alcoholism and drug addiction.
8. pregnancy, except for Complications of Pregnancy when caused by an Accident.

“Complications of Pregnancy” is defined as conditions requiring hospital stays (when the pregnancy is not terminated) whose diagnosis is distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. Complications of pregnancy also includes nonelective caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

9. services performed by a member of the Covered Person's immediate family.

In addition to the exclusions above, We will not pay Medical Expense Benefits for any loss, treatment or services resulting from or contributed to by:

1. suicide, attempted suicide or intentionally self-inflicted injury;
2. war or act of war, whether declared or undeclared. However this does not apply to terrorism.
3. any condition for which the Covered Person is paid benefits under any state or Federal workers' compensation, employers' liability or occupational disease law;
4. the Covered Person's active participation in a riot or insurrection;
5. Injury to which a contributing cause was the Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation;
6. Injury sustained or contracted in consequence of the Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of a Doctor.
7. mental or emotional disorders, alcoholism and drug addiction.

8. pregnancy, except for Complications of Pregnancy.

“Complications of Pregnancy” is defined as conditions requiring hospital stays (when the pregnancy is not terminated) whose diagnosis is distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. Complications of pregnancy also includes nonelective caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

9. services performed by a member of the Covered Person's immediate family.
10. dental care or treatment, except for such care or treatment due to accidental Injury to sound natural teeth within 12 months of the Accident and except for dental care or treatment necessary due to congenital disease or anomaly.

### **Covered Services/Exclusions**

In general, the Policy does not cover experimental or investigational treatments. However, the Policy shall cover an experimental or investigational treatment approved by an External Appeal Agent in accordance with the Appeal Provisions section of the Policy. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only cover the costs of services required to provide treatment to the Covered Person according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the Policy for non-experimental or non-investigational treatments provided in such clinical trial.

## **SECTION 10: CLAIM PROVISIONS**

**Compliance with OFAC:** Payment of loss under the Policy shall only be made in full compliance with all United States of America economic or trade sanction laws or regulations, including, but not limited to sanctions, laws and regulations administered and enforced by the U.S. Treasury Department’s Office of Foreign Assets Control (“OFAC”).

**Notice Of Claim:** A claimant must give Us or Our authorized representative written (or authorized electronic or telephonic) notice of claim within 90 days after any loss covered by the Policy occurs. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible. This notice should identify the Covered Person and the Policy Number.

**Claim Forms:** Upon receiving written notice of claim, We will send claim forms to the claimant within 15 days. If such forms are not furnished before the expiration of 15 days after We receive notice of the claim, the claimant shall be deemed to have complied with the Proof of Loss requirements upon submitting within the time fixed written proof covering the occurrence, character and extent of the loss for which the claim is made.

**Proof Of Loss:** Written (or authorized electronic or telephonic) proof of loss must be sent to the agent authorized to receive it. Written (or authorized electronic or telephonic) proof must be given within 90 days after the date of loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.

**Time Payment Of Claims:** Any benefits due will be paid not more than 60 days after We receive written (or authorized electronic or telephonic) proof of loss.

**Payment Of Claims:** If the Covered Person dies, any death benefits or other benefits unpaid at the time of the Covered Person's death will be paid to the beneficiary. If no beneficiary is on record with Us or Our authorized agent, payment will be made to the first surviving class of the following to the Covered Person's:

1. spouse;
2. children, in equal shares (If a child is a minor, benefits will be paid to the legal guardian);
3. mother or father;
4. estate.

All other benefits due and not assigned will be paid to the Covered Person, if living.

Otherwise, the benefits may, at our option, be paid:

1. according to the beneficiary designation; or
2. to the Covered Person's estate.

If a benefit due is payable to:

1. the Covered Person's estate; or
2. the Covered Person or a beneficiary who is either a minor or is not competent to give a valid release for the payment,

We may pay any amount due to some other person. The other person will be one who we believe is entitled to the payment and who is related to the Covered Person or the beneficiary by blood or marriage. We will be relieved of further responsibility to the extent of any payment made in good faith.

We may pay benefits directly to any Hospital or person rendering covered services, unless the Covered Person requests otherwise in writing. The Covered Person must make the request no later than the time he or she files a written proof of loss.

**Beneficiary:** The Insured may designate a beneficiary. The Insured has the right to change the beneficiary at any time by written (or electronic and telephonic) notice. If the Insured is a minor, his or her parent or guardian may exercise this right for him or her. The change will be effective when We or Our authorized agent receive it. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change.

The Insured is the beneficiary for any covered Dependent.

**Assignment:** At the request of the Covered Person or his or her parent or guardian, if the Covered Person is a minor, medical benefits may be paid to the provider of service. Any payment made in good faith will end our liability to the extent of the payment.

**Physical Examinations And Autopsy:** We have the right to have a Doctor of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

**Legal Actions:** No lawsuit or action in equity can be brought to recover on the Policy: (1) before 60 days following the date proof of loss was given to Us; or (2) after 2 years following the date proof of loss is required.

**Recovery of Overpayment or Error:** If benefits are overpaid, or paid in error, We have the right to recover the amount overpaid, or paid in error, by any or all of the following methods:

1. A request for lump sum payment of the amount overpaid, or paid in error.
2. Reduction of any proceeds payable under the Policy by the amount overpaid, or paid in error.
3. Taking any other action available to Us.

**Subrogation:** In the event that the Covered Person suffers an Injury or illness for which another party may be responsible, such as someone injuring the Covered Person in an Accident, and We pay benefits as a result of that illness or Injury, We will be subrogated and succeed to the Covered Person's right of recovery against the responsible party to the extent of the benefits We have paid. This means that We have the right independently of the Covered Person to proceed against the responsible party to recover the benefits We paid.

**Duty to Cooperate with Us – Possible Penalties for Failure to Cooperate:** Under certain circumstances, We are also entitled to be reimbursed for the benefits We have paid from a settlement or a judgment the Covered Person receives from the party responsible for the Covered Person's illness or Injury. This and other penalties which apply under certain circumstances are noted below: Those circumstances are:

1. The settlement or judgment the Covered Person receives from the party responsible for the Covered Person's illness or Injury specifically identifies or allocates monetary sums directly attributable to expenses for which We have paid benefits; or
2. The Covered Person fails to cooperate with Us in proceeding against the party responsible for the Covered Person's illness or Injury to recover the benefits We have paid. We will pay all expenses associated with a legal action instituted on Our initiative. The penalty for failing to cooperate under Subparagraph "2" above is that the Covered Person will be responsible to repay Us the amount of the benefits We have paid. We agree to invoke Subparagraph "2" only when your illness or Injury caused by a third party results in Our expenditure on Your behalf of an amount exceeding \$500 under this coverage.

## SECTION 11: PREMIUM PROVISIONS

**Premiums:** The premiums for the Policy will be based on the rates currently in force, the plan, and amount of insurance in effect.

**Changes In Premium Rates:** We may change the premium rates on a premium due date with at least 60 days advanced written notice. No change in rates will be made until 12 months after the Policy Effective Date. However, We reserve the right to change rates at any time if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated organization or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. There is a misrepresentation in the information We relied on in establishing the rate.
5. Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

6. the number of Covered Persons or persons eligible for coverage increases or decreases by more than 20% since the later of the Policy Effective Date and the date of the last renewal of this Policy.
7. the ratio of incurred claims to earned premiums since the later of the Policy Effective Date and the last renewal date exceeds the permissible loss ratio.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

**Payment of Premium:** The first premium is due on the Policy Effective Date. After that, premiums will be due annually unless We agree with the Policyholder on some other method of premium payment. The Policyholder shall remit the premium to Us.

If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

**Policy Grace Period:** A Policy Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end upon the expiration of the Grace Period. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

## SECTION 12: GENERAL PROVISIONS

The earned premium will be computed on a pro-rata basis. Any unearned premium will be returned to the Policyholder as soon as practicable.

**Newly Acquired Organizations:** The premium shown on the Schedule of Benefits applies only to the Policyholder and any affiliates or subsidiary corporations covered on the Policy Effective Date. However, eligible employees of organizations acquired by the Policyholder during the Policy Term may be covered based on the following terms. The Policyholder must: (1) report to Us within 60 days or within a reasonable time of the acquisition the name of the newly acquired organization and any underwriting information we may need to calculate the premium; and (2) the required additional premium, if any, must be paid.

**Entire Contract:** The Policy (including any endorsements or amendments), and the signed application of the Policyholder are the entire contract. Any statements made by the Policyholder or Covered Persons will be treated as representations and not warranties. No such statement shall void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application and a copy is provided to the person who made such statement (or their beneficiary or representative).

**Changes:** We reserve the right to make changes in the Policy at the time of renewal. We will give the Policyholder 45 days advance written notice of any change. No agent has authority to change or waive any part of the Policy. To be valid, any change or waiver must be in writing, approved by one of Our officers and evidenced by endorsement on the Policy, or by amendment to the Policy signed by the Policyholder and Us.

**Policy Effective Date And Termination Date:** The Policy begins on the Policy Effective Date at 12:01 AM Standard Time at the address of the Policyholder where the Policy is delivered. Either We or the Policyholder may terminate the Policy on any Premium Due Date by giving 31 days advance written notice to the other party. The Policy may be terminated at any time by mutual written consent of the Policyholder and Us. The Policy terminates automatically on the earlier of:



1) the end of the Policy Term shown in the Schedule of Benefits; or 2) the Premium due date if Premiums are not paid when due, subject to the Grace Period. Termination takes effect at 12:01 AM Standard Time at the Policyholder's address on the date of termination.

**Clerical Error:** If a clerical error is made, it will not affect the insurance of any Covered Person. No error will continue the insurance of a Covered Person beyond the date it should end under the Policy terms.

**Examination Of Records And Audit:** We shall be permitted to examine and audit the Policyholder's books and records at any time during the term of the Policy and within 2 years after the termination of the Policy as they relate to the premiums or subject matter of this insurance.

**Certificates Of Insurance:** We will provide to the Policyholder certificates outlining the insurance coverage and to whom benefits are payable under the Policy.

**Conformity With State Laws:** On the effective date of the Policy, any provision that is in conflict with the laws of the State of New York is amended to conform to the minimum requirements of such laws.

**Not In Lieu Of Workers' Compensation:** The Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits.

**New Entrants:** The Policy will allow from time to time, that new eligible persons of the Policyholder be added to the class(es) of persons originally insured under the Policy.

**Misstatements:** In the absence of fraud, if material facts about a Covered Person were not stated accurately:

- 1) the premium may be adjusted; and
- 2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement made by a Covered Person relating to their insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during their lifetime. In order to be used, the statement must be in writing, signed by the Covered Person and a copy of such statement must be provided to the Covered Person or their beneficiary or representative.

## **SECTION 13: APPEAL PROVISIONS**

### **Internal Appeal Procedure**

If a claim is wholly or partially denied, a written notice or a message on the Explanation of Benefits (EOB) will be sent to You containing the reason for the denial. The notice or message will include a reference to the provision in the Policy and a description of any additional information, which might be necessary for reconsideration of the claim.

If You or Your provider would like additional information or have any complaints concerning the basis upon which payment was made, We may be contacted at 1-800-123-4567. We will address concerns and attempt to resolve them satisfactorily. If We are unable to resolve a concern over the phone, We will request submission of the concern in writing to pursue a formal appeal.

A formal appeal must be submitted, in writing to Us at the following address:

Starr Indemnity & Liability Company

A formal appeal should include:

- Your name, security number, and home address;
- Policy number; and
- Any other information, documentation, or evidence to support the appeal.

A formal appeal must be submitted within 60 days of the event that resulted in the complaint. We will acknowledge a formal appeal within 10 working days of its receipt or within 72 hours if the appeal involves a life-threatening situation. A decision will be sent to You in writing within 30 days following receipt of the formal appeal. If there are extraordinary circumstances requiring a more extensive review and additional supporting documentation is required, We may take up to an additional 60 days to review the formal appeal before rendering a decision.

## **External Appeal Procedure**

### **I. The Insured's Right to an External Appeal**

Under certain circumstances, the Insured has a right to an external appeal of a denial of coverage. Specifically, if We have denied coverage on the basis that the service is not Medically Necessary or is an experimental or investigational treatment, the Insured or his representative may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

### **II. The Insured's Right to Appeal a Determination that a Service is Not Medically Necessary**

If We have denied coverage on the basis that the service is not Medically Necessary, the Insured may appeal to an external appeal agent if the Insured satisfies the following two (2) criteria:

- The service, procedure, or treatment must otherwise be a covered service under the Policy; and
- The Insured must have received a final adverse determination through Our Internal Appeal Procedure described above and We must have upheld the denial **or** the Insured and Us must agree to waive any Internal Appeal.

### **III. The Insured's Right to Appeal a Determination that a Service is Experimental or Investigational**

If the Insured has been denied coverage on the basis that the service is an experimental or investigational treatment, the Insured must satisfy the following two (2) criteria:

- The service must otherwise be a covered service under the Policy; and
- The Insured must have received a final adverse determination through Our Internal Appeal Procedure described above and We must have upheld the denial **or** the Insured and Us must agree in writing to waive any Internal Appeal.

In addition, the Insured's attending Physician must certify that the Insured has a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of the Insured's attending Physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders the Insured unable to engage in any substantial gainful

activities. In the case of a child under the age of eighteen, a “disabling condition or disease” is any medically determinable physical or mental impairment of comparable severity.

The Insured’s attending Physician must also certify that the life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered by the Policy **or** one for which there exists a clinical trial (as defined by law).

In addition, the Insured’s attending Physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to the Insured than any standard covered service (only certain documents will be considered in support of this recommendation – the attending Physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or
- A clinical trial for which the Insured is eligible (only certain clinical trials can be considered).

For purposes of this section, the Insured’s attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat the life-threatening or disabling condition or disease.

#### **IV. The External Appeal Process**

If, through Our Internal Appeal Procedure, the Insured has received a final adverse determination upholding a denial of coverage on the basis that the service is not Medically Necessary or is an experimental or investigational treatment, the Insured has 45 days from receipt of such notice to file a written request for an External Appeal. If the Insured and Us have agreed in writing to waive any internal appeal, the Insured has 45 days from receipt of such waiver to file a written request for an External Appeal. We will provide an External Appeal application with the final adverse determination issued through Our Internal Appeal Procedure or Our written waiver of an Internal Appeal.

The Insured may also request an External Appeal application from the New York State Insurance Department at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application. If the Insured satisfies the criteria for an External Appeal, the State will forward the request to a certified External Appeal Agent.

The Insured will have an opportunity to submit additional documentation with his request. If the External Appeal Agent determines that the information the Insured submits represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an Expedited Appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the Insured’s completed application. The External Appeal Agent may request additional information from the Insured, his Physician, or Us. If the External Appeal Agent

requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify the Insured in writing of its decision within two (2) business days.

If the Insured's attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the Insured's health, the Insured may request an Expedited External Appeal. In that case, the External Appeal Agent must make a decision within three (3) days of receipt of the Insured's completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify the Insured and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify the Insured in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, We will provide coverage subject to the other terms and conditions of the Policy. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only cover the costs of services required to provide treatment to the Insured according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the Policy for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both the Insured and Us. The External Appeal Agent's decision is admissible in any court proceeding.

We will charge the Insured a fee of \$50 for an External Appeal. The External Appeal Application will instruct the Insured on the manner in which he must submit the fee. We will also waive the fee if We determine that paying the fee would pose a hardship to the Insured. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to the Insured.

## **V. The Insured's Responsibilities**

**It is the Insured's RESPONSIBILITY to initiate the External Appeal process.** The Insured may initiate the External Appeal process by filing a completed application with the New York State Insurance Department. The Insured may appoint a representative to assist him with his External Appeal request, however, the Insurance Department may contact the Insured and request that he confirm in writing that he has appointed such representative.

**Under New York State law, the Insured's completed request for appeal must be filed within 45 days of either the date upon which the Insured receives written notification from Us that We have upheld a denial of coverage or the date upon which the Insured receives a written waiver of any Internal Appeal. We have no authority to grant an extension of this deadline.**