

Basic Travel Protection for GOGO Vacations Clients



Cover Page

GOGO Vacations has partnered with Cover-More, Aon Affinity and United States Fire Insurance Company to provide our clients with travel protection. This document holds all of the relevant information you will need in regard to your travel protection plan.

Please review the following two (2) sections:

- **Travel Protection Plan Certificate**
Including Applicable State Exceptions
- **Worldwide Emergency Assistance Services**
Provided by World Travel Protection

Travel Protection Plan Policy

SCHEDULE OF BENEFITS

Benefit Per Trip	Maximum Benefit Amount/Principal Sum
Part A – Travel Arrangement Protection	
Trip Interruption	Total Trip Cost
Travel Delay (Up to \$100 per Day)	\$200
Baggage and Personal Effects	\$800
Baggage Delay	\$100
Accident and Sickness Medical Expense	\$5,000

United States Fire Insurance Company

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

Limited Benefit Short-Term Single Premium Policy

United States Fire Insurance Company, herein referred to as the Company, will pay You (the Insured) the insurance benefits described in this Policy. This Policy and attached Riders, if any, are issued in consideration of the statements in the enrollment form and the payment of the initial premium. This Policy is a legal contract between You and the Company.

This Policy describes all of the travel insurance benefits underwritten by the Company. Please refer to the accompanying Confirmation of Benefits for specific information about the program You purchased. You should contact the Company immediately if You believe that the Confirmation of Benefits is incorrect.

Signed for the Company,

Chairman and CEO,



Marc J. Adee

If the Insured is not completely satisfied with the insurance he or she must notify the Company within 10 days of purchase and return the Policy. The Company will give the Insured a full refund of premium provided he or she has not already departed on the Covered Trip or filed a claim.

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SECTION I. COVERAGES

ACCIDENT MEDICAL EXPENSE

For the purpose of this benefit:

“Covered Expense” means expense incurred for services and supplies: (a) listed below; and (b) ordered or prescribed by a Legally Qualified Physician as Medically Necessary for diagnosis or treatment; which is limited to:

1. The services of a Legally Qualified Physician;
2. Hospital or ambulatory medical-surgical center services (this will also include expenses for a cruise ship cabin or hotel room, not already included in the cost of the Insured’s Covered Trip, if recommended as a substitute for a hospital room for recovery of an Injury);
3. transportation furnished by a professional ambulance company to and/or from a Hospital; and
4. prescribed drugs, prosthetics and therapeutic services and supplies.

Benefits will be paid for the expense incurred, up to the Maximum Benefit Amount, if an Insured incurs a Covered Expense as a result of an accidental Injury, which occurs during the Covered Trip. You must receive the initial Medical Treatment for the Injury within 30 days after the date of the accident, which caused the Injury. All services, supplies or treatment must be received within the 26 weeks following the date of the accident.

Benefits will include expenses for emergency dental treatment due to accidental Injury not to exceed \$1,000.

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

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

The maximum Benefit Amount is shown in the Schedule of Benefits.

SICKNESS MEDICAL EXPENSE

For the purposes of this benefit:

“Covered Expense” means expense incurred for services and supplies: (a) listed below; and (b) ordered or prescribed by a Legally Qualified Physician as Medically Necessary for diagnosis or treatment; which is limited to:

1. The services of a Legally Qualified Physician;
2. Hospital or ambulatory medical-surgical center services (this will also include expenses for a cruise ship cabin or hotel room, not already included in the cost of the Insured’s Covered Trip, if recommended as a substitute for a hospital room for recovery of a Sickness);
3. transportation furnished by a professional ambulance company to and/or from a Hospital; and
4. prescribed drugs, prosthetics and therapeutic services and supplies.

Benefits will be paid for the expense incurred, up to the Maximum Benefit Amount, if You incur a Covered Expense as a result of Sickness, which manifests itself during the Covered Trip. You must receive initial Medical Treatment for the Sickness within 30 days of onset of the Sickness. All services, supplies or treatment must be received within the 26 weeks following the onset of the Sickness.

Benefits will include expenses for emergency dental treatment not to exceed \$1,000.

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

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

The maximum Benefit Amount is shown in the Schedule of Benefits.

TRIP INTERRUPTION

This Coverage is made a part of the policy. It is subject to all the provisions of this Coverage.

Benefits will be paid, up to the Maximum Benefit Amount, for the non-refundable, unused portion of the prepaid expenses for Travel Arrangements and/or the Additional Transportation Cost paid to return home or rejoin the Covered Trip, when You are prevented from completing Your Covered Trip due to:

1. Death involving You or Your Traveling Companion or Your Family Member;
2. A covered Sickness or Injury involving You, Your Traveling Companion, or Your Family Member, or Your Traveling Companion which necessitates Medical Treatment at the time of cancellation and results in medically imposed restrictions, as certified by a Legally Qualified Physician, which prevents an Insured’s participation in the Covered Trip;

Provided such circumstances occurred after Your Effective Date.

The maximum payable under this benefit is the lesser of: a) total cost of Your Covered Trip; or b) the total amount of coverage You purchased.

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

The Maximum Benefit Amount is shown in the Schedule of Benefits.

BAGGAGE AND PERSONAL EFFECTS

This Coverage is provided only if shown as covered in the Schedule of Benefits.

For the purposes of this Benefit:

“Baggage and Personal Effects” means goods being used by an Insured during a Covered Trip. The term Baggage and Personal Effects does not include:

1. animals;
2. automobiles and automobile equipment;
3. boats or other vehicles or conveyances;
4. trailers;
5. motors;
6. aircraft;
7. household effects and furnishings;
8. antiques and collector’s items;
9. eyeglasses, sunglasses, contact lenses, artificial teeth, dental bridges or hearing aids;
10. prosthetic limbs;
11. keys, money, credit cards (except as coverage is otherwise specifically provided herein),
12. securities, stamps, tickets and documents (except as coverage is otherwise specifically provided herein);
13. professional or occupational equipment or property, whether or not electronic business equipment.

For Baggage and Personal Effects: Coverage will be provided to You: (a) against all risks of permanent loss, theft or damage to baggage and personal effects; (b) subject to all Exclusions and Limitations in the policy; (c) up to the Maximum Benefit Amount; and (d) occurring while this coverage is in force.

The lesser of the following amounts will be paid:

- a) the actual cash value (cost less proper deduction for depreciation) at the time of loss, theft or damage;
- b) the cost to repair or replace the article with material of a like kind and quality.
- c) \$250 per article.

A combined maximum of \$400 will be paid for jewelry, watches, articles consisting in whole or in part of silver, gold or platinum, articles trimmed with fur, cameras and their accessories and related equipment.

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

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

Benefits will not be paid for any expenses which have been reimbursed or for any services which have been provided by the Common Carrier, hotel or Travel Supplier; nor will benefits be paid for loss or damage to property specifically schedule under any other insurance.

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

The Maximum Benefit Amount is shown in the Schedule of Benefits.

TRIP DELAY

This Coverage is provided only if shown as covered in the Schedule of Benefits.

If You are delayed for 12 or more hours while in route to or from a Covered Trip, due to:

1. any delay of a Common Carrier. The delay must be certified by the Common Carrier;

Benefits will be paid up to the Maximum Benefit Amount, for:

1. reasonable accommodation and meal expenses up to \$100 per day necessarily incurred by You for which You have proof of purchase and which were not paid for or provided by any other source; and
2. the non-refundable, unused portion of the prepaid expenses for the Covered Trip as long as the expenses are supported by, proof of purchase and are not reimbursable by any other source.

You must provide the following documentation when presenting a claim for these benefits:

- a) Written confirmation of the reasons for delay from the Common Carrier whose delay resulted in the loss, including but not limited to; scheduled departure and return times and actual departure and return times;

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

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

The maximum Benefit Amount is shown in the Schedule of Benefits.

SECTION II. DEFINITIONS

“Additional Transportation Cost” means the actual cost incurred for one-way Economy Transportation by Common Carrier reduced by the value of an unused travel ticket.

“Common Carrier” means any land, sea, and/or air conveyance operating under a valid license for the transportation of passengers for hire.

“Covered Trip” means scheduled trips, tours or cruises for which (a) coverage is requested; and (b) the required premium is submitted prior to the Scheduled Departure Date; (c) a scheduled trip for which coverage is requested and the premium is paid.

“Domestic Partner” means a person who is at least eighteen years of age and can show: 1) evidence of financial interdependence, such as joint bank accounts or credit cards, jointly owned property, and mutual life insurance or pension beneficiary designations; 2) evidence of continuous cohabitation throughout the 180-day period prior to Your Effective Date of the Plan; and 3) an affidavit of domestic partnership if recognized by the jurisdiction within which they reside.

“Economy Transportation” means the lowest published available transportation rate for a ticket on a Common Carrier matching the original class of transportation that the Insured purchased for the Covered Trip.

“Family Member” means Your or a Traveling Companion’s: legal spouse (or common-law spouse where legal); legal guardian; son or daughter (adopted, foster, step or in-law); parent (includes step or in-law); brother or sister (includes step or in-law); grandparent (includes in-law); grandchild; aunt; uncle; niece; nephew; or Domestic Partner.

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

“Injury” or “Injuries” means accidental bodily injuries: (a) received while insured under the Policy and any attached coverages; (b) resulting in loss independently of sickness and all other causes; and (c) not excluded from coverage.

“Insured” means the person(s) named on the enrollment as the principal Participant, participant’s spouse or participant’s child. Insured is also referred to as You or Your.

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

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

“Maximum Benefit Amount” means the maximum amount payable for coverage provided to an Insured as shown in the Schedule of Benefits.

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

“Medically Necessary” means a service or supply which: (a) is recommended by the attending Legally Qualified Physician; (b) is appropriate and consistent with the diagnosis in accord with accepted standards of community practice; (c) could not have been omitted without adversely affecting Your condition or quality of medical care; (d) is delivered at the most appropriate level of care and not primarily for the sake of convenience; and (e) is not considered experimental unless coverage for experimental services or supplies is required by law.

“Pre-existing Condition” means any injury, sickness or condition (including any condition from which death ensues) of the Insured, or Traveling Companion, or Your and/or Traveling Companion’s Family Member scheduled or booked to travel with the You for which within the 60-day period prior to the effective date of Your coverage under the Policy which (a) manifested itself, became acute or exhibited symptoms which would have caused one to seek diagnosis, care or treatment; (b) required taking prescribed drugs or medicine, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or (c) required medical treatment or treatment was recommended by a Legally Qualified Physician.

“Scheduled Departure Date” means the date on which You are originally scheduled to leave on the Covered Trip.

“Scheduled Return Date” means the date on which You are originally scheduled to return to the point of origin or the original final destination.

“Sickness” means an illness or disease that is diagnosed or treated by a Legally Qualified Physician after the effective date of insurance and while You are covered under the Policy.

“Third Party” means a person or entity other than You or the Company.

“Transportation Expense” means: (a) the cost of conveyance of You and any medical personnel (if Medically Necessary); and (b) Medically Necessary services or supplies.

“Travel Arrangements” means: (a) transportation: (b) accommodations: and (c) other specified services arranged by the Travel Supplier for the covered trip.

“Traveling Companion” means a person or persons with whom a covered person has coordinated travel arrangements and intends to travel with during the trip.

“Travel Supplier” means any entity or organization that coordinates or supplies travel services for You.

“Usual and Customary Charges” means those comparable charges for similar treatment, services and supplies in the geographic area where treatment is performed.

SECTION III. INSURING PROVISIONS

Insured’s Term of Coverage:

Policy Term: This Policy is a short-term trip Policy and is issued for the specific term requested. This Policy is not renewable.

For Trip Delay: Coverage is in force while en route to and from the Covered Trip.

For all coverages: Coverage begins at the point and time of departure on the Scheduled Departure Date. Coverage ends at the point and time of return on Your Scheduled Return Date.

In the event the Scheduled Departure Date and/or the Schedule Return Date are delayed, or the point and time of departure and/or point and time of return are changed because of circumstances over which neither the Travel Supplier nor You have control Your term of coverage shall be automatically adjusted accordance with the Travel Supplier’s notice to the Company of the delay or change.

SECTION IV. GENERAL LIMITATIONS AND EXCLUSIONS

Benefits are not payable for Sickness, Injuries or losses of You, Your Traveling Companion or Your Traveling Companion’s Family Member:

1. resulting from an act of declared or undeclared war;
2. while participating in maneuvers or training exercises of an armed service;
3. while piloting or learning to pilot or acting as a member of the crew of any aircraft;
4. received as a result or consequence of being Intoxicated, as specifically defined in the policy, or under the influence of any controlled substance unless administered on the advice of a Legally Qualified Physician;
5. to which a contributory cause was the commission of or attempt to commit a felony or being engaged in an illegal occupation;
6. due to normal childbirth or pregnancy through the first 6 months of pregnancy, or voluntarily induced abortion;
7. due to a Pre-existing Condition, as defined in the Policy.

Additional Limitations and Exclusions Specific to Baggage and Personal Effects

Benefits are not payable for any loss caused by or resulting from:

- a) breakage of brittle or fragile articles;
- b) confiscation or appropriation by order of any government or custom’s rule;
- c) theft or pilferage while left in any unlocked vehicle;
- d) property shipped as freight or shipped prior to the Scheduled Departure Date.

SECTION V. GENERAL PROVISIONS

Entire Contract: Changes: This Policy and any attachments are the entire contract of Insurance. No agent may change it in any way. Only an officer of the Company can approve a change. Any such change must be shown in the Policy or its attachments.

Clerical Error: Clerical Error on the Company’s part or that of a Travel Supplier in keeping records or furnishing information will not void coverage if it is otherwise validly in force; nor will it continue coverage if it is otherwise validly terminated under the terms of this Policy.

Conformity with State Statutes: The provisions of this Policy must conform to the laws of the state in which it was issued. If they do not, they are hereby amended to conform.

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

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

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

Time of Payment of Claims: The Company or its designated representative will pay the claim after receipt of acceptable proof of loss.

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

- a) the Insured's spouse;
- b) the Insured's child or children jointly;
- c) the Insured's parents jointly if both are living or the surviving parent if only one survives;
- d) the Insured's brothers and sisters jointly; or
- e) the Insured's estate.

All or a portion of all other benefits provided by the Policy may, at the option of the Company, be paid directly to the provider of the service(s). All benefits not paid to the provider will be paid to the Insured.

Other than for loss of life, if any benefit is payable to: (a) You or the Insured's beneficiary who is minor or otherwise not able to give a valid release; or (b) the Insured's estate: the Company may pay up to \$1,000 to the Insured's beneficiary or any relative to whom the Company finds entitled to the payment. Any payment made in good faith shall fully discharge the Company to the extent of such payment.

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

Legal Actions: No legal action for a claim can be brought against us until 60 days after we receive proof of loss. No legal action for a claim can be brought against us more than 3 years after the time required for giving proof of loss. This 3-year time period is extended from the date proof of loss is filed and the date the claim is denied in whole or in part.

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

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

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

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

Additional Claims Provisions Specific to Baggage

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

- a) take all reasonable steps to protect, save or recover the property;
- b) promptly notify, in writing, either the police, hotel proprietors, ship lines, airlines, railroad, bus, airport or other station authorities, tour operators or group leaders, or any Common Carrier or bailee who has custody of Your property at the time of loss;
- c) produce records needed to verify the claim and its amount, and permit copies to be made:

- d) provide to the Company, within 90 days from the date of loss, a detailed proof of loss signed and sworn to: and
- e) be examined, if requested.

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

SECTION VI. STATE EXCEPTIONS

KANSAS – Under the General Provisions, “Subrogation” does not apply to reimbursement of medical, surgical, hospital or funeral expenses. “Legal Actions” is amended to read “5-years”. The following exclusion is added to read as follows: 15. due to Mental or Nervous Conditions, unless hospitalized.

“Mental or Nervous Conditions” means disorders specified in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American Psychiatric Association but shall not include conditions not attributable to mental disorders that are a focus of attention or treatment (DSM-IV, 1994).

The definition of Usual and Customary means, for charges incurred in the United States:

- a) charges and fees for medical services or supplies that are the lesser of: the usual charge by the provider for the service or supply given; or the average charges for the service or supply in the area where the service or supply is received; and b) Treatment and medical service that is reasonable in relationship to the service or supply given and the severity of the condition.

Usual and Customary charges are calculated using the national database in Ingenix, Inc. or similar provider. Ingenix and similar providers update the data every 6 months.

For Charges incurred outside the United States, payment is based on billed charges that the Company receives proof of the service or supply being given.

The definition of Family Member is amended to delete the reference to Traveling Companion, as the Traveling Companion is not eligible as a Family Member.

The General Limitation and Exclusions section is amended to delete the reference to Traveling Companion as such person is not eligible as a Family Member.

The definition of Physician is amended to read:

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

Mental and Nervous Disorders

Subject to the terms, limitations, and conditions of the Policy, the Company will cover the following services. The Company will provide coverage for services for treatment of Mental and Nervous Disorders for inpatient confinement for up to 45 days of such Inpatient Confinement per Calendar Year as long as the insurance is in effect on a day of confinement. Inpatient benefits are limited to the Allowable Expense and subject to any deductibles, co-payments and maximum benefit limitations. In addition, the Company will provide coverage for outpatient services for Mental and Nervous Disorders. Outpatient mental health expenses will be covered at 100% of the first \$100 incurred, 80% of the next \$100 incurred and 50% for the next \$1,640 incurred in a calendar year up to a lifetime maximum of \$7,500. Outpatient benefits are limited to the Allowable Expense and subject to any deductibles, co-payments and maximum benefit limitations.

The expense must be incurred while the policy is in force with respect to the covered person or it is not considered an Allowable Expense. The Mental and Nervous Disorder must first be diagnosed while the policy is in force with respect to the covered person and the purpose of the travel may not be for medical treatment of such Mental and Nervous Disorder. Coverage ends on the date the policy terminates.

Mental and Nervous Disorders means the following: Schizophrenia, schizoaffective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis, major affective disorders (bipolar and major depression), cyclothymic and dysthymic disorders, obsessive compulsive disorder, panic disorder, pervasive developmental disorder, including autism, attention deficit disorder and attention deficit hyperactive disorder as such terms are defined in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment.

Diabetes Coverage

Subject to the terms, limitations, and conditions of the Policy, the Company will cover the following services. The Company shall provide coverage for medically necessary equipment and supplies, limited to hypodermic needles and supplies used exclusively with diabetes management and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes if prescribed by Physician. The Company shall also provide coverage for diabetes outpatient

self-management training and education when provided by a certified, registered or licensed health care professional with expertise in diabetes. The coverage for outpatient self-management training and education shall be required only if ordered by a Physician legally authorized to prescribe such services and the diabetic: (1) is treated at a program approved by the American diabetes association; (2) is treated by a person certified by the National Certification Board for Diabetes Educators; or (3) is, as to nutritional education, treated by a licensed dietitian pursuant to a treatment plan authorized a Physician.

The service must be rendered while the covered person is covered under the Policy or it is not considered an Allowable Expense. The benefit is subject to any deductible and maximum benefit limitations required by the Policy. Diabetes must first be diagnosed while the Policy is in force with respect to the covered person and the purpose of the travel may not be for medical treatment of diabetes. Coverage ends on the date the Policy terminates.

General Anesthesia for Dental Surgery

Subject to the terms and conditions of the Policy, the Company will cover the following services. The Company shall provide coverage for the medically necessary administration of general anesthesia and Hospital charges for dental care provided to the following Covered Persons:

- a) a child five years of age and under; or
- b) a person who is severely disabled; or
- c) a person has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.

The service must be rendered while the covered person is covered under this Policy or it is not considered an Allowable Expense. The benefit is subject to any deductible and maximum benefit limitations required by the Policy. The dental work must first be diagnosed while the Policy is in force with respect to the covered person and the purpose of the travel must not be for dental treatment. Coverage ends on the date the Policy terminates.

Off Label Prescription Drugs for Cancer Treatment

Subject to the terms, limitations, and conditions of the Policy, the Company will cover off label prescription drugs as follows. The Company will not exclude coverage of a prescription drug for cancer treatment on the grounds the prescription drug has not been approved by the federal food and drug administration for that covered indication if the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. The prescribing physician shall submit to the Company documentation supporting the proposed off-label use or uses prior to it being covered.

The service must be rendered while the covered person is covered under this Policy or it is not considered an Allowable Expense. The benefit is subject to any deductible and maximum benefit limitations required by the Policy. The cancer must first be diagnosed while the Policy is in force with respect to the covered person and the purpose of the travel must not be to obtain treatment for such cancer or to obtain off label prescription drugs for such cancer treatment. Coverage ends on the date the Policy terminates.

Pregnancy

The following benefit applies to the sickness medical expense benefits ONLY. Subject to all the conditions and limitations of the Policy, including traveling against the advice of a Legally Qualified Physician, the exclusion related to pregnancy or childbirth is deleted in its entirety.

CLAIMS PROCEDURE

1. EMERGENCIES ARISING DURING YOUR COVERED TRIP: Please contact World Travel Protection (refer to Worldwide Emergency Assistance Services section).

2. ALL CLAIMS: Report your claim as soon as possible to Aon Affinity. Provide the policy number, Your travel dates, and details describing the nature of Your loss. Upon receipt of this information, Aon Affinity will promptly forward You the appropriate claim form to complete.

Online: www.aontravelclaim.com

Phone: 1-(800) 539-9277 or 1-(516) 342-7300

Mail: Aon Affinity Travel Practice
900 Stewart Avenue
Garden City, NY 11530

Important: In order to facilitate prompt claims settlement upon your return, be sure to obtain as applicable: detailed medical statements from Physicians in attendance where the Accident or Sickness occurred; receipts for medical services and supplies; receipts from the Hospital; police reports or claims reports from the parties responsible (e.g. airline, cruise line, hotel, etc.) for any loss, theft, damage or delay. In the event of a baggage claim, receipts for any lost or damaged items will be required. In the event of a Baggage Delay or Trip Delay claim, receipts for any additional covered expenses will be required, as well as verification of the delay. You must receive initial treatment within thirty (30) days of the Accident, which caused the Injury, or the onset of the Sickness.

When used throughout this document “The Company”, “Our”, “We”, or “Us” means:
United States Fire Insurance Company

PRIVACY POLICY AND PRACTICES

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

Your Privacy is Our Concern

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

What kind of information do we collect about you and from whom?

We obtain most of our information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?

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

To whom do we disclose information about you?

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

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

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

How to contact Us

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

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

When used throughout this document “Company”, “Our”, “We”, or “Us” means:
United States Fire Insurance Company

GRIEVANCE PROCEDURES

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

DEFINITIONS

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

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

INFORMAL GRIEVANCE PROCEDURE

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

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

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

FORMAL GRIEVANCE PROCEDURE

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

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

First Level Review

Within 3 working business days after receiving the Grievance, we must acknowledge the Grievance and provide you, your authorized representative or a provider with the name, address, and telephone number of the coordinator handling the Grievance and information on how to submit written material. The person(s) who reviews the Grievance will not be the same person(s) who made the initial Adverse Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, a First Level Review. The Insured may, however, submit written material for consideration by the reviewer(s).

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

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

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

Second Level Review

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

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

We must convene a review panel and hold a review meeting within 45-days after receiving a request for a Second Level Review. We will notify you in writing of the meeting date at least 15-days prior to the date. The review meeting will be held during regular business hours at a location reasonable accessible to you. In cases where a face-to-face meeting is not practical for geographic reasons, we will offer you the opportunity to communicate with the review panel at our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not you appear at the meeting.

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

The panel must be comprised of persons who:

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

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

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

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

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

EXPEDITED REVIEW

You are eligible for an expedited review when the timeframes for an Informal, formal First Level review or Second Level review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

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

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance. We will not provide an expedited review for retrospective reviews of Adverse Determinations.

Worldwide Emergency Assistance Services

The following assistance services are provided by World Travel Protection and are not an insurance benefit.

Not a care in the world...when you have our 24/7 global network to assist you on your travels.

- **Travel Assistance**
- **Medical Assistance**
- **Emergency Services**

Travel Assistance

Travel Arrangements

- Arrangements for last-minute flight and hotel changes
- Luggage Locator (reporting/tracking of lost, stolen or delayed baggage)
- Hotel finder and reservations
- Airport transportation
- Rental car reservations and automobile return
- Coordination of travel for visitors to bedside
- Return travel for dependent/minor children
- Assistance locating the nearest embassy or consulate
- Cash transfers
- Assistance with bail bonds

Pre-Trip Information

- Destination guides (hotels, restaurants, etc.)
- Weather updates and advisories
- Passport requirements
- Currency exchange
- Health and safety advisories

Documents and Communication

- Assistance with lost travel documents or passports
- Live email and phone messaging to family and friends
- Emergency message relay service
- Multilingual translation and interpretation services

Medical Assistance Services

- Medical case management, consultation and monitoring
- Medical Transportation
- Dispatch of a doctor or specialist
- Referrals to local medical and dental service providers
- Worldwide medical information, up-to-the-minute travel medical advisories, and immunization requirements
- Prescription drug replacement
- Replacement of eyeglasses, contact lenses and dental appliances

Emergency Services

- Emergency evacuation
- Repatriation of mortal remains
- Emergency medical and dental assistance
- Emergency legal assistance
- Emergency medical payment assistance
- Emergency family travel arrangements

Travel Assistance, Medical Assistance and Emergency Services can be accessed by calling World Travel Protection at **1-800-945-1235** or, from outside the U.S. or Canada, call collect: **1-416-572-3634**.