QBE Insurance Corporation
Harrisburg, Pennsylvania

DESCRIPTION OF COVERAGE

QBE International Essentials
TRAVEL PROTECTION INSURANCE

SECTION 1 — SCHEDULE OF BENEFITS

Per Person	Maximum Limit
Trip Cancellation and Interruption Benefits	100% of Insured Trip Cost
Trip Delay Benefits	$ 500
Emergency Evacuation and Repatriation of Remains Benefits	$50,000
Medical Expense Benefits	$10,000
Dental Expense Benefits	$ 500
Baggage Benefit	$ 500
Baggage Delay Benefit	$ 250

PLEASE READ THIS DOCUMENT CAREFULLY!

The Certificate may be returned within 10 days of receipt for a full refund of any premium paid, as long as You have not already departed on Your Trip or filed a claim.

This plan is underwritten by: QBE Insurance Corporation, rated "A" (Excellent) by A.M. Best Co and administered by Aon Affinity Berkely Travel.
Aon Affinity is the brand name for the brokerage and program administration operations of Affinity Insurance Services, Inc.; (AR 244489); in CA, MN & OK , AIS Affinity Insurance Agency, Inc. (CA 0795465); in CA, Aon Affinity Insurance Services, Inc., (0G94493), Aon Direct Insurance Administrators and Berkely Insurance Agency and in NY and NH, AIS Affinity Insurance Agency. Affinity Insurance Services is acting as a Managing General Agent as that term is defined in the section 626.015(14) of the Florida Insurance Code. As an MGA we are acting on behalf of our carrier partner.

Aon Affinity Berkely Travel, Claims Administrator, Toll-Free Telephone Number: 1-800-453-4075

SECTION 2 — GENERAL DEFINITIONS

"Actual Cash Value" means purchase price for items of the like kind and quality, less depreciation.

"Baggage" means luggage and personal possessions taken by the Insured on the Trip.

"Business Partner" means a person who: (1) is involved with the Insured or the Insured's Traveling Companion in a legal partnership; and (2) is actively involved in the daily management of the business.

"Common Carrier" means an air, land or sea conveyance operated under a license for the transportation of passengers for hire.

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

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

"Covered Trips" means any scheduled Trips for which the Insured requests coverage and remits any required plan cost.

"Departure Date" means the date on which the Insured is originally scheduled to leave on his/her Trip. This date is specified in the travel documents.

"Domestic Partner" means an opposite or a same-sex partner who is at least 18 years of age and has met all of the following requirements for at least 6 months:

(1) resides with the Insured;

(2) shares financial assets and obligations with the Insured;

(3) is not related by blood to the Insured to a degree of closeness that would prohibit a legal marriage; and

(4) neither the Insured or Domestic Partner is married to anyone else, nor has any other Domestic Partner.

The Insurer may require proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

"Eligible Person" means a person who is a member of an eligible class of persons as described in Eligibility in the Schedule of Benefits.

"***Emergency Dental Treatment"*** means Medically Necessary dental care provided to alleviate pain, alleviate the inability to eat or to treat an acute dental condition which presents an immediate and serious threat to the Insured.

"Experimental or Investigative" means treatment, a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used. This includes any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice, and any of those items requiring federal or other governmental agency approval not received at the time services are rendered.

"Family Member" means the Insured's, or Traveling Companion's spouse, Domestic Partner, child, daughter-in-law, son-in-law, brother, sister, mother, father, grandparents, grandchild, step-child, step-brother, step-sister, step-parents, parents-in-law, brother-in-law, sister-in-law, aunt, uncle, niece, nephew, legal guardian, foster child, ward, or legal ward.

"Financial Default" means the total cessation of operations due to insolvency, with or without the filing of a bankruptcy petition by a common carrier, tour operator, cruise line, or airline.

"Hospital" means a facility that:

(1) is operated according to law for the care and treatment of sick or Injured people;

(2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis;

(3) has 24 hour nursing service by registered nurses (R.N.'s); and

(4) is supervised by one or more Physicians available at all times.

A Hospital does not include:

(1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; or

(2) a facility that is, other than incidentally, a clinic, a rest home, nursing home, convalescent home, home health care, or home for the aged; nor does it

include any ward, room, wing, or other section of the hospital that is used for such purposes.

"Inclement Weather" means any severe weather condition which delays the scheduled arrival or departure of a Common Carrier or prevents the Insured from reaching his/her destination.

"Injury/Injured" means a bodily injury caused by an accident occurring while the Insured's coverage under the Policy is in force, and resulting directly and independently of all other causes of Loss covered by the Policy. The injury must be verified by a Physician.

"Insured" means the Eligible Person named on the confirmation who has elected to participate in this insurance program and who has paid the required cost for the insurance.

"Insurer" means QBE Insurance Corporation.

"Loss" means injury or damage sustained by the Insured as a consequence of one or more of the events against which the Insurer has undertaken to compensate the Insured.

"Medically Necessary" means that a treatment, service, or supply:

(1) is essential for diagnosis, treatment, or care of the Injury or Sickness for which it is prescribed or performed;

(2) meets generally accepted standards of medical practice;

(3) is ordered by a Physician and performed under his or her care, supervision, or order; and

(4) is not primarily for the convenience of the Insured, Physician, other providers, or any other person.

"Mental, Nervous, or Emotional Illness or Disorder, Substance Abuse, Alcoholism or Drug Addiction" means these or any related physical manifestation as defined in the most current edition of the "Diagnostic and Statistics Manual of the American Psychiatric Association (DSM).

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

"Necessary Personal Effects" means items such as clothing and toiletry items, which were included in the Insured's Baggage and are required for the Insured's Trip.

"Normal Pregnancy or childbirth" means a pregnancy or childbirth that is free of complications or problems.

"Physician" means a licensed practitioner of the healing arts including accredited Christian Science Practitioners, medical, surgical, or dental, services acting within the scope of his/her license. The treating Physician may not be the Insured, a Traveling Companion, a Family Member or a Business Partner.

"Primary Residence" means a person's fixed, permanent and principal home for legal and tax purposes.

"Quarantined" means the enforced isolation of an Insured and/or the restriction of free movement of an Insured suffering or suspected to suffer from a contagious disease to prevent the spread of contagious disease.

"Reasonable Additional Expenses" means expenses for meals, taxi fares, essential telephone calls and lodging which were necessarily incurred as the result of a Trip Delay and which are not provided by the Common Carrier or any other party free of charge.

"Reasonable and Customary Charges" means an expense which:

(1) is charged for treatment, supplies, or medical services Medically Necessary to treat the Insured's condition;

(2) does not exceed the usual level of charges for similar treatment, supplies or medical services in the locality where the expense is incurred; and

(3) does not include charges that would not have been made if no insurance existed. In no event will the Reasonable and Customary Charges exceed the actual amount charged.

"Return Date" means the date on which the Insured is scheduled to return to the point where the Trip started or to a different specified Return Destination. This date is specified in the travel documents.

"Return Destination" means the place to which the Insured expects to return from his/her Trip.

"Schedule" means the Schedule of Benefits.

"Service Animal" means any guide dog, signal dog, or other animal individually trained to work or perform tasks for the benefit of an individual with a disability, including, but not limited to, guiding persons with impaired vision, alerting persons with impaired hearing to intruders or sounds, providing animal protection or rescue work, pulling a wheelchair, or fetching dropped items.

"Sickness" means an illness or disease diagnosed or treated by a Physician after the Insured's effective date of coverage under the Policy. Sickness does not include any Mental, Nervous, or Emotional Illness or Disorder, Substance Abuse, Alcoholism or Drug Addiction or any related physical manifestation.

"Strike" means a stoppage of work:

(1) announced, organized, and sanctioned by a labor union; and

(2) this interferes with the normal departure and arrival of a Common Carrier.

This includes work slowdowns and sickouts. The Insured's Trip cancellation coverage must be effective prior to when the Strike is foreseeable. A Strike is foreseeable on the date labor union members vote to approve a Strike.

"Third Party" means a person or entity other than an Insured or the Insurer.

"Travel Supplier" means the airline that provides pre-paid travel arrangements for the Insured's Trip.

"Traveling Companion" means up to four people with whom the Insured has coordinated travel arrangements and intends to travel with during the Trip.

"Trip" means (1) a period of round-trip travel to and from a destination that is at least 100 miles from the Insured's Primary Residence; and (2) such travel is not to obtain health care or treatment of any kind.

"Trip Cost" means the dollar amount of Trip payments or deposits which are subject to cancellation penalties or restrictions paid by the Insured prior the Insured's Trip Departure Date. Trip Cost will also include the cost of any subsequent pre-paid payments or deposits paid by the Insured for the same Trip, after enrollment for coverage under this plan provided the Insured pays any required additional plan cost prior to the Insured's Departure Date.

"Unforeseen" means not anticipated or expected and occurring after the effective date of coverage.

"Uninhabitable" means (1) the building structure itself is unstable and there is a risk of collapse in whole or in part; (2) there is exterior or structural damage allowing elemental intrusion, such as rain, wind, hail or flood; (3) immediate safety hazards have yet to be cleared, such as debris on roofs or downed electrical lines; or (4) the rental property is without electricity or water.

"Us", "We", "Our" means QBE Insurance Corporation.

SECTION 3 — INSURED'S EFFECTIVE AND TERMINATION DATES

Insured's Effective Dates. Trip Cancellation coverage elected by or provided for Insureds will take effect on the date the required premium is received by the Insurer. An Insured's coverage begins at 12:01 A.M. Standard Time at their place of residence on the applicable effective date.

All other coverage, except as otherwise specified, elected by or provided for an Insured, will take effect on the scheduled Departure Date provided that the required premium has been paid.

Insured's Termination Dates. Trip Cancellation coverage will end on the earlier of: (1) the cancellation of the Insured's Trip; or (2) the Insured's arrival on the premises on the Departure Date.

For coverages other than Trip Cancellation an Insured's coverage will end on the earliest of the following:

(a) when he or she arrives at the Return Destination;

(b) on the date he or she returns to/arrives at the Return Destination if prior to the Return Date;

(c) when he or she changes his or her Trip (unless due to unforeseen and unavoidable circumstances covered by the Policy).

SECTION 4 — LIMITATIONS

Excess Insurance. The insurance provided by the Policy for all coverages other than Trip Cancellation Benefits and Trip Interruption Benefits shall be in excess of all other valid and collectible insurance and indemnity. If at the time of the occurrence of any Loss payable under the Policy there is other valid and collectible insurance and indemnity in place, the Insurer shall be liable only for the excess of the amount of the Loss, over the amount of such other insurance and indemnity.

Economic or Trade Sanctions. Any payments under the Policy will 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"). Therefore, any expenses incurred or claims made involving travel that is in violation of such sanctions, laws and regulations will not be covered under the policy. For more information, you may consult the OFAC internet website at www.treas.gov/offices/enforcement/ofac/.

SECTION 5 — DESCRIPTION OF BENEFITS

TRIP CANCELLATION AND INTERRUPTION BENEFITS

The Insurer will pay a benefit, up to the Maximum Limit shown on the Schedule, if an Insured cancels his/her Trip or is unable to continue on his/her Trip due to the following Unforeseen events:

(a) Sickness, Injury or death of an Insured, Family Member, Traveling Companion, Service Animal or Business Partner.

  (1) Injury or Sickness of an Insured, Traveling Companion, Family Member Traveling with the Insured or Service Animal, must be so disabling as to reasonably cause a Trip to be canceled, or interrupted. Or which results in medically imposed restrictions as certified by a Physician at the time of Loss preventing your continued participation in the Trip.

  (2) The Insured must cancel or interrupt his/her Trip due to Injury or Sickness of a Family Member not traveling with the Insured, as certified by a Physician.

  (3) Injury or Sickness of the Business Partner must be so disabling as to reasonably cause the Insured to cancel or interrupt the Trip to assume daily management of the business. Such disability must be certified by a Physician.

(b) Strike resulting in complete cessation of travel services at the point of departure or destination for at least 48 consecutive hours;

(c) the Insured's Primary Residence being made Uninhabitable by Natural Disaster, vandalism, or burglary;

(d) the Insured, or a Traveling Companion being subpoenaed, required to serve on a jury, hijacked, or Quarantined;

(e) Insured and/or Traveling Companion is called to active military service or military leave is revoked or reassigned;

(f) the Insured Traveling Companion is involved in an automobile accident, substantiated by a police report, while en route to the Insured's destination;

Trip Cancellation Benefits: The Insurer will reimburse the Insured for forfeited Trip cost up to the Maximum Limit shown on the Schedule for Trips that are canceled prior to the scheduled departure for the Insured's Trip due to the Unforeseen events shown above:

Trip Interruption Benefits: The Insurer will reimburse the Insured up to the Maximum Limit shown on the Schedule for Trips that are interrupted due to the Unforeseen events shown above:

(a) additional transportation expenses incurred by the Insured, either

  (i) to the Return Destination; or

  (ii) from the place that the Insured left the Trip to the place that the Insured may rejoin the Trip; or

(b) additional transportation expenses incurred by the Insured to reach the original Trip destination if the Insured is delayed, and leaves after the Departure Date.

However, the benefit payable under (a) and (b) above will not exceed the cost of economy airfare or the same class as the Insured's original ticket less any refunds paid or payable by the most direct route.

TRIP DELAY BENEFITS

The Insurer will reimburse the Insured up to the Maximum Limit shown on the Schedule for Reasonable Additional Expenses until travel becomes possible if the Insured's Trip is delayed 12 or more consecutive hours from reaching their intended destination as a result of a cancellation or delay of a regularly scheduled airline flight for one of the Unforeseen events listed below:

(a) the Insured being involved in or delayed due to a traffic accident while en route to a departure as substantiated by a police report;

(b) Common Carrier delay;

(c) the Insured's or Traveling Companion's lost or stolen passports, travel documents, or money;

(d) the Insured or Traveling Companion is Quarantined;

(e) Strike.

Incurred expenses must be accompanied by receipts.

EMERGENCY EVACUATION AND REPATRIATION OF REMAINS BENEFITS

The Insurer will pay for Covered Emergency Evacuation Expenses incurred if an Insured suffers an Injury or Sickness while he or she is on a Trip that warrants his or her Emergency Evacuation. Benefits payable are subject to the Maximum Limit shown on the Schedule for all Emergency Evacuations due to all Injuries from the same accident or all Sicknesses from the same or related causes.

"Covered Emergency Evacuation Expenses" are the Reasonable and Customary Charges for necessary transportation, related medical services and medical supplies incurred in connection with the Emergency Evacuation of the Insured. All transportation arrangements made for evacuating the Insured must be by the most direct and economical route possible. Expenses for transportation must be:

(1) ordered by the attending Physician who must certify that the severity of the Insured's Injury or Sickness warrants his or her Emergency Evacuation and adequate medical treatment is not locally available;

(2) required by the standard regulations of the conveyance transporting the Insured; and

(3) authorized in advance by the Insurer. In the event the Insured's Injury or Sickness prevents prior authorization of the Emergency Evacuation, The Insurer must be notified as soon as reasonably possible.

Special Limitation: In the event the Insurer could not be contacted to arrange for Emergency Evacuation transportation, benefits are limited to the amount the Insurer would have paid

had the Insurer or their authorized representation had been contacted.

The Insurer will also pay a benefit for Reasonable and Customary Charges incurred for an escort's transportation and accommodations if an attending Physician recommends in writing that an escort accompany the Insured.

"Emergency Evacuation" means:

(1) the Insured's medical condition warrants immediate transportation from the place where the Insured is injured or sick to the nearest adequate licensed medical facility where appropriate medical treatment can be obtained;

(2) after being treated at a local licensed medical facility, the Insured's medical condition warrants transportation to the Insured's home or adequate licensed medical facility nearest the Insured home to obtain further medical treatment or to recover; or

(3) both (1) and (2) above.

Limitations:

(1) Benefits are only available under Emergency Evacuation if they are not provided under another coverage in the plan.

(2) The Maximum Limit payable for Emergency Evacuation and Repatriation of Remains is shown in the Schedule.

If the Insured is hospitalized for more than 7 days following a covered Emergency Evacuation, the Insurer will pay subject to the limitations set out herein, for expenses for:

(1) Return of children: If the Insured is unable to travel due to a covered Emergency Evacuation, the Insurer will pay to return any of the Insured's children who were accompanying the Insured when the Injury or Sickness occurred back to the Insured's residence in the United States, including the cost of an attendant, if necessary. Such expenses shall not exceed the cost of a one-way economy airfare ticket less the value of any applied credit from any unused return travel tickets for each person.

(2) Bedside Visit: To bring one person chosen by the Insured to and from the medical facility where the Insured is confined if the Insured is alone and is hospitalized for more than 7 days following a covered Emergency Evacuation. The Insurer will pay for expenses to bring one person chosen by the Insured or one Family Member. The payment will not to exceed the cost of one round-trip economy airfare ticket.

REPATRIATION OF REMAINS

The Insurer will pay Repatriation of Remains Covered Expenses to return the Insured's body to their primary residence if he/she dies during the Trip up to the Maximum Limit shown on the Schedule.

Repatriation of Remains Covered Expenses are limited to the expenses incurred to transport the body. The Insurer must make all arrangements and authorize all expenses in advance for this benefit to be payable.

Repatriation of Remains Covered Expenses include, but are not limited to, the expenses for:

(1) embalming;

(2) cremation;

(3) the most economical coffins or receptacles adequate for transportation of the remains; and

(4) transportation, according to airline tariffs, of the remains by the most direct and economical conveyance and route possible.

The Insurer must make all arrangements and authorize all expenses in advance for this benefit to be payable .

Special Limitation: In the event the Insurer or the Insurers' authorized representative could not be contacted to arrange for Repatriation Covered Expenses, benefits are limited to the amount the Insurer would have paid had the Insurer or their authorized representation had been contacted.

MEDICAL EXPENSE BENEFIT

The Insurer will reimburse the Insured up to the Maximum Limit(s) shown on the Schedule if, while on a Trip, an Insured suffers an Injury or a Sickness that requires him or her to be treated by a Physician during the course of the Trip. The Sickness or Injury must first manifest itself during the course of the Trip.

The Insurer will pay the Reasonable and Customary Charges incurred for Medically Necessary Covered Expenses received due to that Injury or Sickness incurred by the Insured within one year from the date of Injury or Sickness provided initial treatment was received during the Trip. The Injury must occur or Sickness must begin while the Insured is covered by the plan.

The Insurer will pay for the following under this Medical Expense Benefit:

(1) services of a Physician or Registered Nurse (R.N.),

(2) Hospital charges;

(3) X-ray(s);

(4) local ambulance services to or from a Hospital;

(5) Physical therapy up to 30 days after the Insured reaches his/her Return Destination

DENTAL EXPENSE BENEFITS

The Insurer will pay this benefit up to the amount shown in the Schedule for the following Covered Expenses incurred by the Insured, subject to the following: 1) Covered Expenses will only be payable at the Reasonable and Customary level of payment; 2) benefits will be payable only for Covered Expenses resulting from an Injury that occurs while on a Trip; 3) the Insured must first receive treatment during his or her Trip; and 4) benefits payable as a result of incurred Covered Expenses will only be paid after benefits have been paid under all other valid and collectible insurance and indemnity in place for the Insured.

Covered Dental Expenses are expenses up to the Maximum shown in the Schedule for Emergency Dental Treatment incurred by the Insured during his/her Covered Trip.

The Insured's duties in the event of a Dental Expense:

(1) The Insured must provide the Insurer with all bills and reports for dental expenses claimed.

(2) The Insured must provide any requested information, including but not limited to, an explanation of benefits from any other applicable insurance.

(3) The Insured must sign a patient authorization to release any information required by the Insurer to investigate his/her claim.

BAGGAGE BENEFITS

The Insurer will reimburse the Insured, up to the Maximum Limit shown in the Schedule subject to the special limitations shown below, for Loss, theft or damage to the Insured's Baggage, personal effects, passports, travel documents, and visas during the Insured's Trip.

Special Limitations:

The Insurer will not pay more than:

(1) $250 per each item;

(2) $500 aggregate on all losses to: jewelry, watches, furs, cameras and camera equipment, camcorders, computers, and other electronic devices, including but not limited to: portable personal computers, cellular phones, electronic organizers and portable Compact Disc players.

The Insurer will pay the lesser of:

(1) Actual Cash Value; or

(2) the cost of replacement.

The Insurer may take all or part of the damaged Baggage at the appraised or agreed value. In the event of a loss to a pair or set of items, the Insurer may at its option:

(1) repair or replace any part to restore the pair or set to its value before the loss; or

(2) pay the difference between the value of the property before and after the loss.

BAGGAGE DELAY BENEFITS

If the Insured's Baggage is delayed or misdirected by the Common Carrier for more than 24 hours while on a Trip, the Insurer will reimburse the Insured up to the Maximum Limit shown on the Schedule for the purchase of Necessary Personal Effects. Incurred expenses must be accompanied by receipts. This benefit does not apply if Baggage is delayed after the Insured has reached his/her Return Destination.

SECTION 6 —EXCLUSIONS

GENERAL EXCLUSIONS

This plan does not cover any insured Loss caused by or resulting directly or indirectly from:

(1) pregnancy, childbirth, or elective abortion, other than Complications of Pregnancy;

(2) participation in professional athletic events, motor sport, or motor racing, including training or practice for the same;

(3) mountaineering where ropes or guides are normally used. The ascent or descent of a mountain requiring the use of specialized equipment, including but not limited to pick-axes, anchors, bolts, crampons, carabineers, and lead or top-rope anchoring equipment;

(4) war or act of war, whether declared or not, civil disorder, riot, or insurrection;

(5) operating or learning to operate any aircraft, as student, pilot, or crew;

(6) air travel on any air-supported device, other than a regularly scheduled airline or air charter;

(7) Loss or damage caused by detention, confiscation, or destruction by customs;

(8) any unlawful acts, committed by the Insured, a Family Member, or a Traveling Companion, or Business Partner whether insured or not;

(9) Mental, Nervous, or Emotional Illness or Disorder, Substance Abuse, Alcoholism or Drug Addiction or any related physical manifestation or rest cures;

(10) if the Insured's tickets do not contain specific travel dates (open tickets);

(11) use of drugs, narcotics, or alcohol, unless administered upon the advice of a Physician;

(12) any failure of a provider of travel related services (including any Travel Supplier) to provide the bargained-for travel services or to refund money due the Insured;

(13) Experimental or Investigative treatment or procedures;

(14) any Loss that occurs at a time when this coverage is not in effect.

(15) traveling for the purpose of securing medical treatment;

(16) care or treatment which is not Medically Necessary;

(17) any Trip taken outside the advice of a Physician;

(18) Financial Default;

(19) any problem or event that could have reasonably been foreseen or expected when coverage under the Policy was purchased;

(20) Participation in extreme, high-risk sports, i.e., skydiving, hang gliding or parachuting; bungee jumping; caving; extreme skiing, heli-skiing or skiing outside marked trails; body contact sports (meaning any sport where the objective is to physically render an opponent unable to continue with the competition such as boxing and full contact karate); SCUBA diving below 120 feet (40 meters) without a dive master.

ADDITIONAL EXCLUSIONS

The following additional exclusions apply to Trip Cancellation and Trip Interruption:

Benefits will not be provided for any Loss resulting (in whole or in part) from:

(1) travel arrangements canceled by an airline, except as provided elsewhere in the plan;

(2) financial circumstances of the Insured, a Family Member, or a Traveling Companion;

(3) any business or contractual obligations of the Insured, a Family Member, or Traveling Companion;

(4) any government regulation or prohibition;

(5) an event which occurs prior to the Insured's coverage Effective Date;

(6) failure of any tour operator, Common Carrier, person or agency to provide the bargained-for travel arrangements.

The following additional exclusions apply to Baggage and Baggage Delay:

Benefits will not be provided for any loss or damage to or resulting (in whole or in part) from:

(1) animals, rodents, insects or vermin;

(2) bicycles (except when checked with a Common Carrier);

(3) motor vehicles, aircraft, boats, boat motors, ATV's and other conveyances;

(4) artificial prosthetic devices, false teeth, any type of eyeglasses, sunglasses, contact lenses, or hearing aids;

(5) tickets, keys, notes, securities, accounts, bills, currency, deeds, food stamps or other evidences of debt, credit cards, and other travel documents (except passports and visas);

(6) money, stamps, stocks and bonds, postal or money orders;

(7) property shipped as freight, or shipped prior to the Departure Date;

(8) contraband, illegal transportation or trade.

(9) items seized by any government, government official or customs official;

(10) defective materials or craftsmanship;

(11) normal wear and tear;

(12) deterioration;

(13) mysterious disappearance;

(14) breakage of brittle or fragile articles, such as cameras, camera equipment and accessories, cellular phones, wireless handheld devices, musical instruments, radios, and similar property;

(15) theft or pilferage while left unattended in any vehicle.

SECTION 7 —CLAIMS PROVISIONS

Notice of Claim: The Insured must call the Insurer's claims administrator at 1-800-453-4075 as soon as reasonably possible, and be prepared to describe the Loss, the name of the entity that arranged the Trip, the Trip dates, and the amount that the Insured paid. The Insurer's claims administrator will process the claim.

Claim Forms: Upon receiving notice of claim, the Insurer's claims administrator will send claim forms to the claimant within 15 days. The proof must describe the occurrence, extent and nature of the loss.

Proof of Loss: All Proof of Loss under the Policy must be submitted to the Insurer's claims administrator no later than one year after the date of Loss or insured occurrence or as soon as reasonably possible.

Payment of Claims: When Paid: Claims will be paid as soon as the Insurer's claims administrator receives complete proof of Loss.

Payment of Claims: To Whom Paid:

Benefits are payable to the Insured who applied for coverage and paid any required plan cost. Any benefits payable due to that Insured's death, will be paid to the survivors of the first surviving class of those that follow:

(1) the Beneficiary named by that Insured and on file with the Insurer. If no Beneficiary named, then

(2) to his/her spouse, if living. If no living spouse, then

(3) in equal shares to his/her living Children. If there are none, then

(4) in equal shares to his/her living parents. If there are none, then

(5) in equal shares to his/her living brothers and sisters. If there are none, then

(6) to the Insured's estate.

Trip Cancellation and Trip Interruption Payment of Loss: The Insured must provide the Insurer documentation of the cancellation or interruption and proof of the expenses incurred. The Insured must provide proof of payment for the Trip such as canceled check or credit card statements, proof of refunds received, copies of applicable tour operator or Common Carrier cancellation policies, and any other information reasonably required to prove the Loss. Claims involving Loss due to Sickness, Injury, or death require signed patient (or next of kin) authorization to release medical information and an attending Physician's statement. The Insured must provide the Insurer with all unused air tickets if he/she is claiming the value of those unused tickets.

Baggage Delay Payment of Loss: The Insured must provide documentation of the delay or misdirection of Baggage by the Common Carrier and receipts for the Necessary Personal Effects purchases.

Medical Expense Payment of Loss: The Insured must provide the Insurer with: (a) all medical bills and reports for medical expenses claimed; and (b) a signed patient authorization to release medical information to the Insurer.

ADDITIONAL CLAIMS PROCEDURES

The following provisions apply to Baggage and Baggage Delay:

Notice of Loss. If the Insured's property covered under the Policy is lost or damaged, the Insured must:

(1) notify the Insurer as soon as possible;

(2) take immediate steps to protect, save and/or recover the covered property;

(3) give immediate notice to the carrier who is or may be liable for the loss or damage;

(4) notify the police or other authority in the case of robbery or theft within 24 hours.

Proof of Loss. The Insured must furnish the Insurer with proof of loss. Proof of loss includes police or other local authority reports or documentation from the appropriate party responsible for the loss. It must be filed within 90 days from the date of loss. Failure to comply with these conditions shall not invalidate any claims under the Policy.

Valuation. The Insurer will not pay more than the Actual Cash Value of the property at the time of loss. At no time will payment exceed what it would cost to repair or replace the property with material of like kind and quality.

The following provision applies to Medical Expense, Emergency Evacuation and Repatriation of Remains:

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

As a condition to receiving the applicable benefits listed above, as they pertain to this Subrogation provision, the Insured agrees, except as may be limited or prohibited by applicable law, to reimburse the Insurer for any such benefits paid to or on behalf of the Insured, if such benefits are recovered, in any form, from any Third Party or Coverage.

"Coverage" as used in this Subrogation section, means no fault motorist coverage, uninsured motorist coverage, underinsured motorist coverage, or any other fund or insurance policy (except coverage provided under the Policy to which this Description of Coverage is attached) and any fund or insurance policy providing the Policyholder with coverage for any claims, causes of action or rights the Insured may have against the Policyholder).

"Third Party" as used in this Subrogation section, means any person, corporation or other entity (except the Insured, the Policyholder and the Insurer).

SECTION 8 — GENERAL PROVISIONS

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

Assignment. An Insured may assign all of his or her rights, privileges and benefits under the Policy. The Insurer is not bound by an assignment until it receives and files a signed copy. The Insurer is not responsible for the validity of assignments. The assignee only takes such rights

as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.

Conformity With State Laws. On the effective date of the Policy, any provision that is in conflict with the laws in the state where it is issued is amended to conform to the minimum requirements of such laws.

Legal Actions. No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Concealment or Fraud. The Insurer does not provide coverage if the Insured has intentionally concealed or misrepresented any material fact or circumstance relating to the policy or claim.

Payment of Premium. Coverage is not effective unless all premium due has been paid to the Insurer or its authorized representative prior to a date of Loss or insured occurrence.

Termination of the Policy. Termination of the policy will not affect a claim for Loss which occurs while the policy is in force.

Transfer of Coverage. Coverage under the policy cannot be transferred by the Insured to anyone else.

STATE SPECIFIC NOTICES

Notice to Alabama Residents:

QBTE-0001(11-10)-AL

The definition of Physician in GENERAL DEFINITIONS is deleted in its entirety and replaced by the following:

"Physician" means a person who is:

1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art, including, but not limited to, a podiatrist, a certified nurse anesthetist, a dental assistant and a physician assistant;

2) licensed to practice in the jurisdiction where care is being given;

3) practicing within the scope of that license; and

4) not related to the Insured by blood or marriage.

Exclusion (11) in GENERAL EXCLUSIONS pertaining to use of drugs is deleted and replaced as follows:

(11) Loss caused by, contributed to or resulting from the Insured's intoxication or being under the influence of any drug or narcotic, except as prescribed by a Physician.

The Payment of Claims: When Paid provision appearing in the CLAIMS PROVISIONS is deleted and replaced as follows:

Payment of Claims: When Paid: The Insurer's claims administrator will pay benefits due under the Policy not more than 45 calendar days upon receipt of a clean written proof of loss or 30 calendar days upon receipt of a clean electronic proof of loss. If they are denying or pending the claim, they shall, within 45 calendar days for a written claim and 30 calendar days for an electronic claim, notify the health care provider or Insured of the reason for denying or pending the claim and what, if any, additional information is required to process the claim. The Insurer's claims administrator shall pay or deny or otherwise adjudicate the claim within 21 calendar days from the receipt of the requested information. If they fail to meet these deadlines and the claim is found to be payable, the amount of the overdue claim shall include an interest payment of 1.5 percent per month prorated daily from the date that payment was overdue.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

The Legal Actions provision in GENERAL PROVISIONS is amended to read "6 years".

Notice to Alaska Residents

QBTP-0002(11-10)-AK

The definitions of Baggage, Experimental or Investigative, Physician and Reasonable and Customary Charges in GENERAL DEFINITIONS are deleted and replaced as follows:

"Baggage" means luggage, travel documents, and personal possessions, bicycles when checked as baggage with Common Carrier musical instruments hunting equipment including but not limited to: guns, rods, reels, tackle, bows, arrows, fishing equipment, ski gear, including but not limited to: skis, sporting equipment ski poles, ski bindings, boots, snowboards, golf equipment SCUBA diving equipment whether owned, borrowed, or rented, taken by the Insured on the Trip.

"Experimental or Investigative" means treatment, a device or prescription medication requiring federal or other governmental agency approval not received at the time services are rendered. The treating Physician will be responsible for determining whether or not it is Experimental or Investigative.

"Physician" means a licensed health care provider acting within the scope of their occupational license. It includes, but is not limited to, a state licensed physician, physician assistant, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, marital and family therapist, psychologist, psychological associate, licensed clinical social worker, licensed professional counselor, or certified direct-entry midwife. It does not include a person related to the Covered Person by blood or marriage.

"Reasonable and Customary Charges" means the lesser of: (a) the actual charge made by the provider; or (b) the 80th percentile of a statistically credible database (updated at least every six months) that contains billed charges for each geographical area. When the Insurer pays a claim, The Insurer will show the above calculation of the "Reasonable and Customary Charges" for that claim and whether or not the Insured is responsible for any amount billed that exceeds the amount the Insurer have paid.

The following is added at the end of the definition of Medically Necessary in GENERAL DEFINITIONS:

The treating Physician will be responsible for determining whether or not it is Experimental or Investigative.

The Excess Insurance provision in LIMITATIONS shall not apply to the Baggage Benefit or the Baggage Delay Benefit.

The following are added to item (3) under Special Limitations in BAGGAGE BENEFITS:

Sporting equipment, musical instruments

The Payment of Claims: When Paid provision in CLAIMS PROVISIONS is deleted and replaced as follows:

Payment of Claims: When Paid: Claims will be paid within 30 working days after the Insurer's Claims Administrator receives complete proof of Loss.

The following is added as the third provision under ADDITIONAL CLAIMS PROCEDURES in CLAIMS PROVISIONS:

Settlement of Loss. Claims for damage and/or destruction shall be paid immediately after proof of the damage and/or destruction is presented to the Insurer. Claims for lost property will be paid after the lapse of a reasonable time if the property has not been recovered. The Insured must present acceptable proof of loss and the value.

Notice to Arizona Residents:

QBTE-0001(11-10)-AZ

The Subrogation provision appearing in the CLAIMS PROVISIONS is deleted and shall not apply.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

The following provision is added to the CLAIMS PROVISIONS:

Complaints and Grievances: If the Insured has a complaint regarding this Description of Coverage, they may contact Berkely at 1-800-453-4075. Berkely will attempt to informally resolve the complaint. Any person submitting a formal written complaint will receive a written reply explaining in detail the resolution and additional levels through which a complaint may be appealed. The written procedure for complaints is available to an Insured upon their request.

Notice to Arkansas Residents:

QBTE-0001(11-10)-AR

The following notice is added to the face page:

BENEFIT PAYMENTS ARE SUBJECT TO THE BENEFIT MAXIMUMS STATED ON THE SCHEDULE OF BENEFITS.

The following is added to the MEDICAL EXPENSE BENEFITS:

(f) The following outpatient services provided they would be covered if performed on an inpatient basis: laboratory and pathological tests, including machine tests, ordered by the attending Physician when necessary to and rendered in conjunction with the medical or surgical diagnosis or treatment of a covered Injury or Sickness.

The following is added to Payment Of Claims: When Paid in the CLAIMS PROVISIONS:

1. The Insurer's claims administrator shall pay or deny a Clean Claim within 30 days after they receive it if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means.
2. The Insurer's claims administrator shall notify the claimant within 30 days after receipt of the claim if they determine that more information is needed to resolve one or more issues. Their notice shall give an explanation of the additional information that is required. They may suspend the claim until they receive the requested information. They shall reopen and pay or deny a previously suspended claim within 30 days after they receive all the information the Insurer requested.
3. If the Insurer's claims administrator fails to pay or deny a Clean Claim in accordance with item 1. above or give notice in accordance with item 2. above, they shall pay a penalty to the claimant for the period beginning on the sixty-first day after receipt of the Clean Claim and ending on the Clean Claim payment date (the delinquent payment period), calculated as follows: the amount of the Clean Claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. Such payment shall be paid without any action by the claimant.
4. If the Insurer's claims administrator fails to pay or deny a claim in accordance with item 2. above which is not already subject to the penalty for the claim im-

posed by item 3. above, they shall pay a penalty to the claimant for the period beginning on the forty-sixth day after the last item of information requested was received and ending on the claim payment date (the delinquent payment period), calculated as follows: the amount of the claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. Such payment shall be paid without any action by the claimant.

"Clean Claim" means a claim for payment that is submitted on a HCFA 1500, on a UB92, in a format required by HIPAA, or on the Insurer's standard claim form with all required fields completed in accordance with its published claim filing requirements. A Clean Claim shall not include a claim: (1) for payment of expenses incurred during a period of time for which premiums are delinquent; or (2) for which the Insurer needs additional information in order to resolve one or more issues.

The following items are added to the GENERAL PROVISIONS at the end:

The Insurance Company may be contacted at its Administrative Office:

QBE Insurance Corporation
Wall Street Plaza, 88 Pine Street, 4th Floor
New York, NY 10005, 1-877-772-6771

The State Insurance Department may be contacted at:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904,
1-800-852-5494 or 501-371-2640

Guaranty Association Notice:

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the Disclaimer below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan partici-

pants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which benefits could be provided out of the assets of the impaired or insolvent insurer.

Notice to California Residents:

QBTE-0001(11-10)-CA

The following is added at the bottom of the face page:

NOTICE: This plan contains disability insurance benefits or health insurance benefits, or both, that only apply during the covered trip. You may have coverage from other sources that already provides you with these benefits. You should review your existing policies. If you have any questions about your current coverage, call your insurer or health plan.

The definition of Domestic Partner in GENERAL DEFINITIONS is deleted and replaced as follows:

"Domestic Partner" means two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring who have a valid Declaration of Domestic Partnership filed with the California Secretary of State pursuant to Section 298 of the Family Code or an equivalent document issued by a local agency of California, another state, or a local agency of another state under which the partnership is created. the Insurer may ask for a copy of such document or for notification of termination of the domestic partnership only if a married person would be required to provide verification of marital status or notification of the termination of the marriage.

Any provision applicable to a spouse will be equally applicable to a Domestic Partner.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

The following is added to the CLAIMS PROVISIONS:

Assignment of Ambulance Services Benefits: Benefits for ambulance services shall be payable directly to the provider of the ambulance services. This shall be done unless the Insurer receives proof that such benefits have already been paid.

The Subrogation provision in CLAIMS PROVISIONS is deleted and replaced as follows:

Reimbursement: If an Insured has an Injury caused by a third party's wrongful act or negligence:

(a) The Insurer will pay Policy benefits for that Injury subject to the Insurer's Reimbursement Rights and on condition that the Insured (or the legal representative of the Insured):

  (1) will not take any action which would prejudice the Insurer's Reimbursement Rights; and

  (2) will cooperate in doing what is reasonably necessary to assist the Insurer in enforcing its Reimbursement Rights (including signing a reimbursement agreement or other document upon the Insurer's written request).

(b) The Insurer's Reimbursement Rights will not be reduced because:

  (1) the recovery does not fully compensate the Insured for all losses sustained or alleged; or

  (2) the recovery is not described as being related to medical costs.

(c) The Insurer may enforce its Reimbursement Rights by filing a lien with the third party, the third party's insurer or another insurer, a court having jurisdiction in this matter or any other appropriate party.

(d) The amount of the Insurer's reimbursement will not be reduced by legal fees or court costs incurred in seeking the recovery, unless the Insurer agrees otherwise in writing.

(e) The Insurer may elect to charge any reimbursement due the Insurer under this provision against any further benefit payments for the Insured under the Policy. This will not reduce the Insurer's right to be paid first out of any recovery up to the amount of Policy benefits not yet reimbursed.

"Reimbursement Rights" means the Insurer's right to be reimbursed if:

(a) The Insurer pays Policy benefits for an Insured because of an Injury caused by a third party's wrongful act or negligence; and

(b) an Insured or the legal representative of an Insured recovers an amount from the third party, the third party's insurer, an uninsured motorist insurer or anyone else by reason of the third party's wrongful act or negligence.

This recovery may be the result of a lawsuit, a settlement or some other act. The Insurer is entitled to be paid first out of any recovery, up to the amount of Policy benefits the Insurer paid.

The following provision is added to the CLAIMS PROVISIONS:

Independent Medical Review

When an Insured feels that a Disputed Health Care Service has been improperly denied, modified or delayed by the Insurer, he or she may request an Independent Medical Review provided all of the following conditions are met:

- His or her Doctor recommended the health care service as Medically Necessary; or he or she received Medical Emergency treatment and the attending Doctor determined that such care was Medically Necessary;
- The Disputed Health Care Service is denied, modified or delayed by the Insurer based in whole or in part on the decision that the health care service is not Medically Necessary; and
- he or she has already filed a grievance with the Insurer and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days;

The request for an Independent Medical Review must be within six (6) months of any of the events listed above.

To initiate the Independent Medical Review, the Insured must submit the one-page application form in the addressed envelope provided by the Insurer when the Insurer sends notification of the Insurer's response to the grievance. The form will include any information needed to complete the Independent Medical Review.

The form will also include:

- Notice to the Insured that non-participation in the independent review process may cause him or her to forfeit any statutory right to pursue legal action against the Insurer regarding the grievance;
- A signed statement indicating his or her consent to obtain any necessary medical records from the Insurer and any providers he or she may have consulted on the matter;

- Notice of his or her right to provide information or documentation, either directly or through the Insurer regarding any of the following:
  - A provider recommendation indicating that the Disputed Health Care Service is Medically Necessary for his or her medical condition;
  - Medical information or justification that a Disputed Health Care Service, on a medical emergency basis, was Medically Necessary for his or her condition;
  - Reasonable information supporting his or her position that the Disputed Health Care Service is or was Medically Necessary for his or her medical condition, including all information provided to him or her by the Insurer still in their possession, concerning any decisions regarding Disputed Health Care Services. Also, a copy of any materials they submitted to the Insurer that is still in their possession, in support of the grievance, as well as any additional material that they believe is relevant.

The confidentiality of any medical information will be maintained pursuant to applicable state and federal laws.

"Disputed Health Care Service" means any health care service eligible for coverage and payment under the Policy that has been denied, modified, or delayed by a decision by the Insurer, in whole or in part due to a finding that the service is not Medically Necessary.

"Independent Medical Review" means a process to complete an initial screening of an Insured's grievance.

Notice to Connecticut Residents:

QBTE-0001(11-10)-CT

The following is added to the face page:

The Policy shall be made available to any certificate holder upon request.

The definition of Hospital in the GENERAL DEFINITIONS is deleted and replaced with the following:

"Hospital" means a facility that:

(1) is operated according to law for the care and treatment of sick or Injured people;

(2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis;

(3) has 24 hour nursing service by registered nurses (R.N.'s); and

(4) is supervised by one or more Physicians available at all times.

A Hospital does not include:

(1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care;

(2) a facility that is, other than incidentally, a clinic, a rest home, nursing home, convalescent home, home health care, or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes.

The Excess Insurance provision in LIMITATIONS is deleted and shall not apply.

Exclusion (8) pertaining to any unlawful acts and Exclusion (9) in GENERAL EXCLUSIONS are deleted and replaced with the following:

(8) Injury sustained or Sickness contracted in the commission of a felony;

(9) The treatment of mental or nervous disorders, alcoholism, or loss caused by the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by his Physician for the Covered Person.

The Payment of Claims: When Paid provision in CLAIM PROVISIONS is deleted and replaced as follows:

Payment of Claims: When Paid: The Insurer's claims administrator will pay claims not later than 45 days after receipt by them of the Insured Person's proof of loss form or the health care provider's request for payment filed in accordance with the Insurer's practices or procedures, except that when there is a deficiency in the information needed for processing a claim, they shall (a) send written notice to the Insured or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than 30 days after they receive a claim for payment or reimbursement under the policy, and (b) pay claims for payment or reimbursement under the policy not later than 30 days after they receive the information requested.

If the Insurer's claims administrator fails to pay such a claim within the time periods set forth above, they shall pay the Insured or health care provider the amount of such claim plus interest at the rate of 15% per annum, in addition to any other penalties which may be imposed pursuant to Connecticut law.

Notice to Delaware Residents:

QBTE-0001(11-10)-DE

EXCLUSION (4) in the GENERAL EXCLUSIONS, pertaining to war or an act of war, shall not apply to terrorism.

The Payment of Claims: When Paid provision, in CLAIM PROVISIONS, is replaced with the following:

Benefits for Loss covered by the Policy will be paid not more than 60 days after the Insurer's claims administrator receives proper written proof of such loss.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

Notice to District of Columbia Residents:

QBTE-0001(11-10)-DC

The following is added to the face page:

SHORT-TERM NON-RENEWABLE COVERAGE

The definition of Domestic Partner in GENERAL DEFINITIONS is deleted and replaced as follows:

"Domestic Partner" means an unmarried same or opposite sex adult who resides with the Insured and has registered in a state or local domestic partner registry with the Insured.

Item (d) in the MEDICAL EXPENSE BENEFIT is deleted and replaced as follows.

(d) Medically Necessary air or ground ambulance services to or from a Hospital.

The following is added as Item (f) in the MEDICAL EXPENSE BENEFIT:

(f) Emergency Services for treatment of a Medical Emergency.

"Emergency Services" means:

1. health care services furnished in the emergency department of a Hospital for treatment of a Medical Emergency;
2. Ancillary Services routinely available to the emergency department of a Hospital for treatment of a Medical Emergency; and
3. emergency medical services transportation.

"Ancillary Services" means standard medical procedures that are reasonably necessary for the diagnosis and treatment of a patient.

"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. It also includes the sudden worsening of a medical condition.

Exclusion (11) in GENERAL EXCLUSIONS is deleted and replaced with the following:

(11) Injury sustained from or during the voluntary use of illegal drugs; the intentional taking of over the counter medication not in accordance with recommended dosage and warning instructions; and intentional misuse of prescription drugs.

The "Notice of Claim" provision in CLAIMS PROVISIONS is deleted and replaced as follows:

Notice of Claim: Written Notice of Claim must be given to the Insurer's claims administrator within 20 days after the occurrence or commencement of any Loss covered by the Policy, or as soon as reasonably possible. If the Insured is still on the Covered Trip, they may call the Insurer's claims administrator at 1-800-453-4075 as soon as reasonably possible, and be prepared to describe the Loss, the name of the entity that arranged the Trip (i.e., the Insured, tour operator, cruise line, or charter operator), the Trip dates, and the amount that the Insured paid. The Insurer's Claims Administrator will process the claim.

The Payment of Claims: When Paid provision in CLAIMS PROVISIONS is deleted and replaced as follows:

Payment of Claims: When Paid: Claims will be paid immediately after the Insurer's claims administrator receives complete proof of Loss.

The following is added to the end of GENERAL PROVISIONS:

Important Information Regarding the District of Columbia Life & Health Insurance Guaranty Association Act of 1992

Summary of General Purposes and Current Limitations of Coverage

Residents of the District of Columbia who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in the District of Columbia to write these types of insurance are members of the District of Columbia Life and Health Insurance Guaranty Association. The purpose of the Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the District of Columbia and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is limited, however, as noted below.

Disclaimer

The District of Columbia Life and Health Guaranty Association provides coverage of claims under some types of

policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned on residence in the District of Columbia. Other conditions may also preclude coverage.

The District of Columbia Life and Health Guaranty Association or the District of Columbia Insurance Commissioner will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on availability of coverage under the Life and Health Guaranty Association Act of 1992 when selecting an insurer. Policyholders with additional questions may contact:

Mr. Thomas E. Hampton
Commissioner
District of Columbia Department of Insurance,
Securities and Banking
810 First Street, N.E.
Suite 701
Washington, DC 20002
(202) 727-8000

Mr. Robert M. Willis
Executive Director
District of Columbia Life and Health
Insurance Guaranty Association
1200 G Street, N.W.
Washington, DC 20005
(202) 434-8771
Fax: (202) 347-2990

The District of Columbia law that provides for this safety-net coverage is called the District of Columbia Life and Health Guaranty Association Act of 1992. This page contains a brief summary of the law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

Coverage

Generally, individuals will be protected by the District of Columbia Life and Health Guaranty Association if they live in the District of Columbia and are insured under a health insurance, life insurance, or annuity contract issued by a member insurer, or they are insured under a group insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of insured persons are protected as well, even if they live in another state.

Exclusions from Coverage

However, persons holding such policies are not protected by this Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside of that state of incorporation;
- Their insurer was not authorized to do business in the District of Columbia; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits or fees for services in connection with the policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contracts.

Limits on amount of coverage

The Act also limits the amount the Guarantee Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- with respect to any one life, regardless of the number of policies, contracts, or certificates:

- $300,000 in life insurance death benefits but not more than $100,000 in net cash surrender or net cash withdrawal values for life insurance; or
- $100,000 in health insurance benefits, including net cash surrender or net cash withdrawal values; or
- $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values.

Finally, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.

Notice to Florida Residents:

QBTE-0001(11-10)-FL

The following is added to the face page:

To make an inquiry, obtain information about your coverage or to resolve a complaint call 1-800-453-4075

EXCESS INSURANCE

The following is added at the end of the definition of Hospital in GENERAL DEFINITIONS:

Hospital also includes a licensed emergency treatment center. The center must have permanent facilities and:

(1) a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) present at all times;

(2) an M.D. specialist representing each of the major specialties available within minutes;

(3) ancillary services, including laboratory and X-ray, staffed at all times; and

(4) a pharmacy staffed, or on call, at all times.

Hospital also includes a licensed hospital primarily of a rehabilitative nature, regardless of whether it has surgical facilities or not, if such rehabilitation is specifically for treatment of physical disability.

With respect to outpatient surgery or diagnostic testing, an ambulatory surgical center or a clinic will be considered as a Hospital. Such facility must be properly accredited and, where required by law, hold a license allowing the facility to operate as such.

The definition of Reasonable and Customary Charges in GENERAL DEFINITIONS is deleted and replaced as follows:

"Reasonable and Customary Charges" means the fee regularly charged and received for a given service by a health care provider when furnishing customary treatment for a similar condition or Injury as represented by the 70-100th percentile of the MDR database. The Insurer shall provide to an Insured, upon his written request, an estimate of the amount the Insurer will pay for a particular

procedure or service. However, the Insurer will not be bound by such good faith estimate.

The following is added as the 3rd paragraph of the MEDICAL EXPENSE BENEFIT provision:

Note: Treatment performed outside the Hospital will be paid the same is if performed in a Hospital provided it would have been covered on an inpatient basis.

The following is added to the MEDICAL EXPENSE BENEFIT:

(6) Charges for general anesthesia and Hospital services in conjunction with necessary dental care provided to an Insured who:

(1) Is under 8 years of age and is determined by a licensed dentist, and the child's Physician, to require necessary dental treatment in a Hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or

(2) Has one or more medical conditions that would create significant or undue medical risk for the Insured in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or ambulatory surgical center.

For purposes of this benefit, dental treatment or surgery shall be considered necessary when the dental condition is likely to result in a medical condition if left untreated.

The following is added at the end of the MEDICAL EXPENSE BENEFIT:

EXTENSION OF BENEFITS

If the Insured is Totally Disabled when insurance under the Policy ends, the Insurer will provide for the continuation of the same Medical Expense Benefit in connection with the treatment of a covered Loss incurred while the Policy was in effect. Such benefits will only be extended to the earlier of 90 days from the date the coverage ends; the date the maximum amount of benefits have been paid; or the end of the Total Disability.

"Totally Disabled" or ***"Total Disability"*** means, as a result of Injury or Sickness, the Insured is wholly and continuously prevented from:

(1) performing the material and substantial duties of their regular occupation; or

(2) if not employed, engaging in the normal activities of a person of like age and gender in good health.

Exclusion (4) in GENERAL EXCLUSIONS is amended to include the following at the end:

However, this Exclusion does not apply to terrorism.

Payment will be treated as being made on the date a draft or other valid instrument which is equivalent to payment is placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. All overdue payments will bear simple interest at the rate of 10 percent per year.

Upon written notice by the Insured, the Insurer's claims administrator will investigate any claim of improper billing by a Physician, Hospital or other health care provider. They will determine if the Insured was properly billed for only those procedures and services that they actually received. If they determine that they have been improperly billed, they will notify the Insured and the provider of the Insurer's findings and they will reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notice by an Insured they will pay the Insured 20% of the amount of the reduction up to $500.

The Subrogation provision in CLAIMS PROVISIONS is deleted and replaced as follows*:*

Subrogation. If the Insurer has paid benefits to an Insured for an Injury, and in the Insurer's opinion a Third Party may be liable, the Insurer will be subrogated to the extent of such payment and to all rights of the Insured regarding recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Insured agrees to sign papers and do whatever is necessary to transfer His rights to the Insurer. the Insurer will exercise such rights on His behalf. The Insured further agrees to furnish the Insurer with all relevant information and documents. In no case will the Insurer receive an amount greater than the total amounts of benefits the Insurer has paid for such Injury.

"Third Party" as used in this Subrogation section, means any person, corporation or other entity (except the Insured, the Policyholder and the Insurer).

The last sentence appearing in the Legal Actions provision in GENERAL PROVISIONS is deleted and replaced as follows:

No such action may be brought after the expiration of the applicable statute of limitations.

Notice to Georgia Residents:

QBTE-0001(11-10)-GA

The following is added at the bottom of the face page:

THE POLICY DOES NOT COVER MENTAL ILLNESS

The following is added to the INSURED'S EFFECTIVE AND TERMINATION DATES provision:

(d) the date he or she provides the Insurer with written notice that they want their coverage terminated.

The Excess Insurance provision appearing in the LIMITATIONS is deleted and shall not apply.

The following is added at the end of MEDICAL EXPENSE BENEFITS:

If an Insured is totally disabled due to an Injury covered under the Policy when insurance under the Policy ends, the Insurer will provide for the continuation of the same Policy benefits in connection with the treatment of a covered Loss incurred while the Policy was in effect. Such benefits will only be extended to the earlier of 365 days from the date the coverage ends or the end of the total disability. Any benefits payable under this provision will not exceed the benefit maximums shown in the Schedule.

In the Claim Forms section in the CLAIM PROVISIONS, "15 days" is replaced with "10 days."

In the Payment of Claims: When Paid section in the CLAIM PROVISIONS, the following is added:

Medical Expense Benefit amounts due under the Policy for a Loss will be paid upon receipt of due written Proof of Loss. The Insurer's claims administrator shall, within 15 working days after such receipt, mail payment for such benefits or a notice which states the reasons for failing to pay the claim, in whole or in part, and which gives the Insured, or the Insured's beneficiary, a written itemization of any information needed to process the claim or any portions thereof which are not being paid. Where a portion of the claim is disputed, any undisputed portion shall be paid. When all of the information needed to process the claim has been received, the Insurer's claims administrator shall then have 15 working days to either mail payment for the claim or a notice denying it, in whole or in part, giving the Insured, or the Insured's beneficiary, the reasons for such denial. They shall pay interest equal to 18% per annum on the benefits due for failure to comply with this provision.

In the Payment of Claims: To Whom Paid section in the CLAIMS PROVISIONS, the following is added:

Where an Insured and their beneficiary both die and there is not sufficient evidence that both died otherwise than simultaneously, benefits will be paid as if the Insured had survived the beneficiary.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

The Subrogation provision appearing in the CLAIMS PROVISIONS is deleted and shall not apply.

Notice to Hawaii Residents:

QBTE-0001(11-10)-HI

All references to Domestic Partner are replaced by "Reciprocal Beneficiary" and the following definition is added to the GENERAL DEFINITIONS:

"Reciprocal Beneficiary" means the Insured's partner who has a current valid "Declaration of Reciprocal Beneficiary Relationship" filed with the Hawaii Director of Health in accordance with Chapter 572C, Hawaii Revised Statutes. Any provision applicable to a spouse will be equally applicable to a Reciprocal Beneficiary.

The following is added to the definition of Physician in the GENERAL DEFINITIONS:

Physician includes a licensed optometrist, dentist, psychologist, clinical social worker and advanced practice registered nurse.

The Proof of Loss provision in the CLAIMS PROVISIONS is amended to read "15 months".

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

The Payment of Claims: When Paid provision in the CLAIMS PROVISIONS is amended to include the following at the end:

For Medical Expense Benefits, a claim that is not contested or denied shall be paid not more than 30 calendar days after the Insurer's claims administrator receives the claim if filed in writing, or 15 calendar days after they receive the claim if filed electronically. If a claim is contested or denied or requires more time for review, the Insurer's claims administrator shall notify the health care provider in writing or electronically not more than 15 calendar days after receiving a claim filed in writing, or not more than 7 calendar days after receiving a claim filed electronically. The notice shall identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may request additional information. If information received pursuant to a request for additional information is satisfactory to warrant paying the claim, the claim shall be paid not more than 30 calendar days after receiving the additional information in writing, or not more than 7 calendar days after receiving the additional information filed electronically. Payment of a claim shall be effective upon the date of the postmark of the mailing of the payment, or the date of the electronic transfer of the payment.

Interest shall be paid at a rate of 15% a year for money owed by the Insurer on payment of a claim exceeding the applicable time limitations above, as follows:

(a) For an uncontested claim:

(1) Filed in writing, interest from the first calendar day after the 30-day period specified above; or

(2) Filed electronically, interest from the first calendar day after the 15-day period specified above.

(b) For a contested claim filed in writing:

(1) For which notice was provided as specified above, interest from the first calendar day 30 days after the date the additional information is received; or

(2) For which notice was not provided within the time specified above, interest from the first calendar day after the claim is received.

(c) For a contested claim filed electronically:

(1) For which notice was provided as specified above, interest from the first calendar day 15 days after the additional information is received; or

(2) For which notice was not provided within the time specified above, interest from the first calendar day after the claim is received.

Any interest that accrues on delayed clean claims shall be automatically added by the Insurer to the amount of the unpaid claim due.

Notice to Idaho Residents:

QBTE-0001(11-10)-ID

The following notice is added to the face page:

NOTICE TO BUYER: THIS IS AN ACCIDENT-ONLY POLICY/CERTIFICATE AND IT DOES NOT PAY BENEFITS FOR LOSS FROM SICKNESS. REVIEW YOUR POLICY/CERTIFICATE CAREFULLY.

The definition of Complications of Pregnancy in GENERAL DEFINITIONS is deleted and replaced with the following:

"Complications of Pregnancy" means:

a. Conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are 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, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis qravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and

b. Cesarean section delivery, ectopic pregnancy which is terminated, spontaneous termination of pregnancy

which occurs during a period of gestation in which a viable birth is not possible, puerperal infection, eclampsia and toxemia.

The Excess provision in LIMITATIONS is deleted and shall not apply.

In the MEDICAL EXPENSE BENEFIT, all references to Sickness are deleted and shall not apply, and all references to the term are deleted throughout this Description of Coverage.

The Concealment or Fraud provision in the GENERAL PROVISIONS is deleted.

The following notice is added to the GENERAL PROVISIONS:

Contact Information for the Idaho Department of Insurance:

Idaho Department of Insurance
Consumer Affairs
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

Notice to Illinois Residents:

QBTE-0001(11-10)-IL

The following definition is added to the GENERAL DEFINITIONS:

"Accident" means an unexpected event that results in Injury to an Insured.

The definition of Injury/Injured in the GENERAL DEFINITIONS is deleted and replaced with the following:

"Injury/Injured" means bodily harm which results from an Accident, independent of disease or bodily infirmity. All injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

The following is added to the MEDICAL EXPENSE BENEFIT:

(m) treatment for a Medical Emergency.

"Medical Emergency" means a medical condition with acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

The first sentence in the GENERAL EXCLUSIONS is amended by removing the phrase "or indirectly".

GENERAL EXCLUSIONS Item (8) is deleted and replaced as follows:

(8) commission of a felony by an Insured.

In the Payment Of Claims: When Paid section in the CLAIMS PROVISIONS, the following is added:

Medical Expense Benefit Claims not paid within 30 days following the Insurer's claims administrator's receipt of proper proof of loss shall entitle the claimant to interest at the rate of 9% per annum from the 30th day after receipt of such proof of loss to the date of late payment.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

The Subrogation provision appearing in the CLAIMS PROVISIONS is deleted and replaced as follows:

Right of Reimbursement: If an Insured incurs expenses for a Loss that occurred due to the negligence of a third party:

(1) The Insurer has the right to reimbursement for all benefits it paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Insured, Insured's parents, if the Insured is a minor, or Insured's legal representative as a result of that Loss; and

(2) The Insurer is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits it paid for that Loss.

The Insurer shall have the right to first reimbursement out of all funds the Insured, the Insured's parents, if the Insured is a minor, or the Insured's legal representative, is or was able to obtain for the same expenses the Insurer has paid as a result of that Loss.

The Insured is required to furnish any information or assistance or provide any documents that the Insurer may reasonably require in order to obtain the Insurer's rights under this provision. This provision applies whether or not the third party admits liability.

Notice to Indiana Residents:

QBTE-0001(11-10)-IN

The following notice is added to the face page:

Questions regarding the Policy or Your coverage should be directed to:

Aon Affinity Berkely Travel
1-800-453-4075

If You (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint You have been unable to resolve with Your insurer You may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at
www.in.gov/idoi.

The Excess Insurance provision in LIMITATIONS is deleted and shall not apply.

Exclusion (11) in GENERAL EXCLUSIONS pertaining to use of drugs is deleted and replaced as follows:

(11) Injury or Loss sustained or contracted as a consequence of being legally intoxicated as determined according to the laws of the jurisdiction in which the Injury or Loss occurred or Injury or Loss sustained or contracted as a consequence of being under the influence of any narcotic unless administered on the advice of a Physician.

The Payment of Claims: When Paid provision in CLAIM PROVISIONS is deleted and replaced as follows:

Payment Of Claims: When Paid: Any benefits due will be paid immediately after the Insurer's claims administrator receives written (or authorized electronic or telephonic) proof of loss. They shall pay or deny each Clean Claim as follows: (1) if the claim is filed electronically, within 30 days after the date the Insurer receives the claim; or (2) if the claim is filed on paper, within 45 days after the date they receive the claim. They shall notify a claimant of any deficiencies in a submitted claim not more than: (1) 30 days for a claim that is filed electronically; or (2) 45 days for a claim that is filed on paper; and describe any remedy necessary to establish a Clean Claim. Their failure to notify a claimant as required above establishes the submitted claim as a Clean Claim. If they fail to pay or deny a Clean Claim in the time required above, and subsequently pay the claim, they shall pay the claimant interest, at the rate prescribed by Indiana law, on the allowable amount of the claim paid. Interest accrues beginning: (1) 31 days after the date the electronic claim is filed; or (2) 46 days after the date the paper claim is filed; and stops on the date the claim is paid.

A ***"Clean Claim"*** means a claim submitted for payment that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

The following provision is added at the end of the CLAIM PROVISIONS:

Internal Grievance Procedure

A ***"grievance"*** means any dissatisfaction expressed by or on behalf of an Insured regarding:

1) a determination that a service or proposed service is not appropriate or Medically Necessary;

2) a determination that a service or proposed service is experimental or investigational;

3) the availability of participating providers;

4) the handling or payment of claims for health care services; or

5) matters pertaining to the contractual relationship between:

   (A) an Insured and the Insurer; or

   (B) the Policyholder and the Insurer;

and for which the Insured has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

An Insured may file a grievance orally or in writing. Insureds may call the Insurer's toll free telephone number 1-877-772-6771 through which a grievance may be filed. A grievance is considered to be filed on the first date it is received, either by telephone or in writing. The Insurer has established procedures to assist Insureds in filing grievances. An Insured may designate a representative to file a grievance for the Insured and to represent the Insured in a grievance.

The Insurer's grievance procedures include the following:

1) Acknowledgment of the grievance, given orally or in writing, to the Insured within five (5) business days after receipt of the grievance.

2) Documentation of the substance of the grievance and any actions taken.

3) An investigation of the substance of the grievance, including any aspects involving clinical care.

4) Notification to the Insured of the disposition of the grievance and the right to appeal.

5) Standards for timeliness in:

   (A) responding to grievances; and

   (B) providing notice to Covered Persons of:

      (i) the disposition of the grievance; and

      (ii) the right to appeal;

   that accommodate the clinical urgency of the situation.

A grievance shall be resolved as expeditiously as possible, but not more than twenty (20) business days after the Insurer receives all information reasonably necessary to complete the review. If the Insurer is unable to make a

decision regarding the grievance within the twenty (20) day period due to circumstances beyond its control, it shall:

(1) before the twentieth business day, notify the Insured in writing of the reason for the delay; and

(2) issue a written decision regarding the grievance within an additional ten (10) business days.

The Insurer shall notify an Insured in writing of the resolution of a grievance within five (5) business days after completing an investigation. The grievance resolution notice must include the following:

(1) A statement of the decision reached by the Insurer.

(2) A statement of the reasons, policies, and procedures that are the basis of the decision.

(3) Notice of the Insured's right to appeal the decision.

(4) The department, address, and telephone number through which an Insured may contact a qualified representative to obtain additional information about the decision or the right to appeal.

Appeals of Grievance Decisions

An Insured may file an appeal of a grievance decision orally or in writing. The Insurer's appeal procedures include the following:

(1) Written or oral acknowledgment of the appeal not more than five (5) business days after the appeal is filed.

(2) Documentation of the substance of the appeal and the actions taken.

(3) Investigation of the substance of the appeal, including any aspects of clinical care involved.

(4) Notification to the Insured:

   (A) of the disposition of an appeal; and

   (B) that the Covered Person may have the right to further remedies allowed by law.

(5) Standards for timeliness in:

   (A) responding to an appeal; and

   (B) providing notice to Insureds of:

      (i) the disposition of an appeal; and

      (ii) the right to initiate an external grievance review under IC 27-8-29;

   that accommodate the clinical urgency of the situation.

An appeal of a grievance decision shall be resolved:

(1) as expeditiously as possible, reflecting the clinical urgency of the situation; and

(2) not later than forty-five (45) days after the appeal is filed.

The Insurer shall allow an Insured the opportunity to:

(1) appear in person before; or

(2) if unable to appear in person, otherwise appropriately communicate with the review panel.

The Insurer shall notify an Insured in writing of the resolution of an appeal of a grievance decision within five (5) business days after completing the investigation. The appeal resolution notice shall include the following:

(1) A statement of the decision reached by the Insurer.

(2) A statement of the reasons, policies, and procedures that are the basis of the decision.

(3) Notice of the Insured's right to further remedies allowed by law, including the right to external grievance review by an independent review organization under IC 27-8-29.

(4) The department, address, and telephone number through which an Insured may contact a qualified representative to obtain more information about the decision or the right to an external grievance review.

External Review of Grievances

An external grievance procedure is available for the resolution of external grievances regarding:

(1) an adverse determination of appropriateness;

(2) an adverse determination of Medical Necessity;

(3) a determination that a proposed service is experimental or investigational; or

(4) a denial of coverage based on a waiver described in IC 27-8-5-2.5 or IC 27-8-5-19.2;

made by the Insurer or an agent of the Insurer regarding a service proposed by the treating health care provider.

The Insurer's external grievance procedure shall:

(1) allow an Insured or an Insured's representative to file a written request with the Insurer for an external grievance review of its:

   (A) appeal resolution of a grievance; or

   (B) denial of coverage based on a waiver described in IC 27-8-5-2.5 or IC 27-8-5-19.2;

   not more than forty-five (45) days after the Insured is notified of the resolution; and

(2) provide for:

   (A) an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame

for a standard review would seriously jeopardize the Insured's:

(i) life or health; or

(ii) ability to reach and maintain maximum function; or

(B) a standard external grievance review for a grievance not described in clause (A). An Insured may file not more than one (1) external grievance of the Insurer's appeal resolution. An Insured shall not pay any of the costs associated with the services of an independent review organization under this external review procedure. All costs must be paid by the Insurer. An Insured who files an external grievance:

(1) shall not be subject to retaliation for exercising the Insured's right to an external grievance;

(2) shall be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;

(3) shall be permitted to submit additional information relating to the proposed service throughout the review process; and

(4) shall cooperate with the independent review organization by:

(A) providing any requested medical information; or

(B) authorizing the release of necessary medical information.

The Insurer shall cooperate with an independent review organization by promptly providing any information requested by the independent review organization.

An independent review organization shall:

(1) for an expedited external grievance, within three (3) business days after the external grievance is filed; or

(2) for a standard appeal, within fifteen (15) business days after the appeal is filed;

make a determination to uphold or reverse the Insurer's appeal resolution of a grievance based on information gathered from the Insured or the Insured's designee, the Insurer, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.

When making the determination, the independent review organization shall apply:

(1) standards of decision making that are based on objective clinical evidence; and

(2) the terms of the Insured's accident and sickness insurance policy.

In an external grievance, the Insurer bears the burden of proving that it properly denied coverage for a condition, complication, service, or treatment because the condition, complication, service, or treatment is directly related to a condition for which coverage has been waived under IC 27-8-5-2.5 or IC 27-8-5-19.2.

The independent review organization shall notify the Insurer and the Insured of their determination:

(1) for an expedited external grievance, within twenty-four (24) hours after making the determination; and

(2) for a standard external grievance, within seventy-two (72) hours after making the determination.

Upon the request of an Insured who is notified that the independent review organization has made a determination, the independent review organization shall provide to the Insured all information reasonably necessary to enable the Insured to understand the:

(1) effect of the determination on the Insured; and

(2) manner in which the insurer may be expected to respond to the determination.

A determination made under this external review of grievances procedure is binding on the Insurer.

If, at any time during an external review performed, the Insured submits information to the Insurer that is relevant to its resolution of the Insured's appeal of a grievance decision and that was not considered by the Insurer:

(1) The Insurer may reconsider the resolution; and

(2) if the Insurer chooses to reconsider, the independent review organization shall cease the external review process until the reconsideration is completed.

If the Insurer reconsiders the resolution of an appeal of a grievance decision due to the submission of new information, it shall reconsider the resolution based on the information and notify the Insured of its decision:

(1) within seventy-two (72) hours after the information is submitted, for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the Insured's:

(A) life or health; or

(B) ability to reach and maintain maximum function; or

(2) within fifteen (15) days after the information is submitted, for a reconsideration not described in item 1) above.

If the decision reached is adverse to the Insured, the Insured may request that the independent review organization resume the external review. If the Insurer chooses not to reconsider its resolution of a grievance, it shall forward the submitted information to the independent review organization not more than two (2) business days after the Insurer's receipt of the information.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

Notice to Iowa Residents:

QBTE-0001(11-10)-IA

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

Notice to Kansas Residents:

QBTE-0001(11-10)-KS

The definition of Domestic Partner in the GENERAL DEFINITIONS is deleted along with all references to this term and shall not apply.

The definition of Reasonable and Customary Charges in GENERAL DEFINITIONS is deleted and replaced as follows:

"Reasonable and Customary Charges" 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, as represented by the 80th percentile of statistically valid fee data published in the MDR database, which is updated at least every six months.

The Excess Insurance provision appearing in the LIMITATIONS is deleted and shall not apply.

The following is added to the MEDICAL EXPENSE BENEFIT:

(f) Charges for manipulative therapies, not to exceed $500 per policy year.

(g) Charges for those services within the lawful scope of practice of an advanced registered nurse practitioner. Benefits will be paid for such charges irrespective of whether the service was provided or performed by a Physician or an advanced registered nurse practitioner.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

The Subrogation provision in CLAIMS PROVISIONS is deleted and shall not apply.

The Legal Actions provision in the GENERAL PROVISIONS is amended to read "5 years".

The Concealment or Fraud provision appearing in the GENERAL PROVISIONS is deleted.
The following provision is added to the GENERAL PROVISIONS:

Errors Related to Your Coverage: The Insurer the right to correct benefit payments that are made in error. The Insured has the responsibility to return any overpayments to the Insurer. The Insurer has the responsibility to make additional payments if any underpayments have been made.

Notice to Kentucky Residents:

QBTE-0001(11-10)-KY

The following notice is added to the face page:
The Policy is a legal contract between the Policyholder and the Insurer.

READ YOUR POLICY CAREFULLY. This cover sheet provides only a brief outline of some of the important features of your Policy. This cover sheet is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. IT IS THEREFORE IMPORTANT THAT YOU READ YOUR POLICY.

The definition of Sickness in GENERAL DEFINITIONS is deleted along with all references to the term and does not apply.

The definition of Physician in GENERAL DEFINITIONS is deleted and replaced with the following:

"Physician" means a legally licensed practitioner of the healing arts including, but not limited to, physicians, osteopaths, optometrists, certified surgical assistants, physician assistants, podiatrists, licensed nurses, chiropractors or dentists, practicing within the scope of his or her license to treat the condition causing loss.

Physician does not include:

(1) An Insured;

(2) a Family Member; or

(3) the Policyholder.

Exclusion (11) in GENERAL EXCLUSIONS is deleted and replaced with the following:

(11) any Loss sustained or contracted in consequence of the Insured's being intoxicated or under the influence of any narcotic or any hallucinogenic unless administered on the advice of a Physician.

Exclusion (19) in GENERAL EXCLUSIONS pertaining to any problem or event that could have reasonably been foreseen or expected when coverage under the Policy was purchased is deleted and shall not apply.

The Notice of Claim provision in CLAIMS PROVISIONS is deleted and replaced with the following:

Written notice of claim must be given to the Insurer within twenty (20) days after the date when such loss occurred. Failure to give notice within such time shall not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. The Insured may call the Insurer's claims administrator] at 1-800-453-4075 for assistance.

The following is added to the Proof of Loss provision in CLAIMS PROVISIONS:

Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible.

The Payment of Claims: When Paid provision in CLAIMS PROVISIONS is deleted and replaced as follows:

Payment of Claims: When Paid: If benefits are payable, the Insurer's claims administrator will pay the benefits in accordance with the Payment of Claims: To Whom Paid provision within 30 days after they receive Proof of Loss. If they fail to make a good faith attempt to settle the claim within 30 days, the value of the final settlement shall bear interest at the rate of 12% per annum from and after the expiration of the 30 day period. If they fail to settle a claim within 30 days and delay was without reasonable foundation, the claimant shall be entitled to be reimbursed for their reasonable attorney's fees incurred. No part of the fee for representing the claimant in connection with this claim shall be charged against benefits otherwise due the claimant.

Notice to Louisiana Residents

QBTP-0001(11-10)-LA

The following is added at the end of the definition of Hospital in GENERAL DEFINITIONS:

The Insurer shall not exclude payment of benefits for services rendered by a medical facility owned or operated by the state of Louisiana or any of its political subdivisions, whether it be a general hospital, a mental hospital, a tubercular hospital, or a geriatric hospital.

Surgery performed in an ambulatory surgical center shall be covered on the same basis as if performed as an inpatient in a Hospital.

The definition of Medically Necessary in GENERAL DEFINITIONS is deleted along with all references to the term and does not apply.

The following is added to the GENERAL DEFINITIONS:

"Medical Emergency" means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

The definition of Physician in GENERAL DEFINITIONS is amended to include the following:

Physician also includes, but is not limited to, a duly licensed: chiropractor, podiatrist, optometrist, psychologist, and clinical social worker. The Insurer shall not deny coverage of perioperative services rendered by a registered nurse first assistant if it covers the same such first assistant perioperative services when they are rendered by an advanced practice nurse, a physician assistant, or a physician other than the operating surgeon.

Item (3) in the definition of "Reasonable and Customary Charges" in GENERAL DEFINITIONS is amended to include the following:

However this Item (3) does not apply to services rendered by a medical facility owned or operated by the State of Louisiana or any of its political subdivisions.

Items (f), (g), and (h) are added to the MEDICAL EXPENSE BENEFIT:

(6) Medical Emergency services necessary to screen, evaluate, and stabilize a Medical Emergency.

(7) Services performed by a qualified interpreter/transliterator, other than a family member of the Insured:

1. when such services are used in connection with treatment or diagnostic consultations performed by a Physician; and
2. provided such treatment or consultation is a covered service; and
3. provided the services are required because of hearing impairment of the Insured or his failure to understand or otherwise communicate in spoken language.

(8) Services performed via transmitted electronic imaging or telemedicine by a Physician conducting or participating in the transmission at the originating facility or terminus who is physically present with the Insured who is the subject of such electronic imaging transmission and contemporaneously communicating and interacting with the Physician at the receiving terminus of the transmission. Benefits for the services of the Physician at the originating facility or terminus will be paid at the same co-insurance rate as for Physician's office visits, but in no event will the Insurer pay more than 75% of the Reasonable and Customary Charge which that Physician receives for an intermediate office visit.

Exclusion (16) in GENERAL EXCLUSIONS pertaining to care and treatment which is not Medically Necessary is deleted and does not apply.

The "Payment of Claims: When Paid" provision in CLAIMS PROVISIONS is deleted and replaced as follows:

Payment of Claims: When Paid: All claims arising under the terms of the Policy shall be paid not more than thirty days from the date upon which written notice and proof of claim, in the form required by the terms of the Policy, are furnished to the Insurer's claims administrator unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. Failure to comply with this provision shall subject the Insurer to a penalty payable to the Insured of double the amount of the benefits due under the terms of the Policy during the period of delay, together with attorney's fees to be determined by the court.

The Subrogation provision in CLAIMS PROVISIONS is deleted and replaced as follows:

Subrogation: To the extent that benefits are provided or paid under the Policy, The Insurer shall be subrogated to all rights of recovery which any Insured may acquire against any other party for the recovery of the amount paid under the Policy, however the Insurer's right of subrogation is secondary to the right of the Insured to be fully compensated for his damages. The Insured agrees to deliver all necessary documents or papers, to execute and deliver all necessary instruments, to furnish information and assistance, and to take any action the Insurer may require to facilitate enforcement of its right of subrogation. The Insurer agrees to pay its portion of the Insured's attorney's fee or other costs associated with a claim or lawsuit to the extent that the Insurer recovers any portion of the benefits paid under the Policy pursuant to its right of subrogation.

Notice to Maine Residents

QBTE-0001(11-10)-ME

The following notices are added to the face page:

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS POLICY/CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY.

If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

The following definition is added to GENERAL DEFINITIONS:

"Accident" means accidental bodily Injury sustained by an Insured that is the direct cause of the condition for which benefits are provided and that occurs while the Policy is in force.

The definition of Domestic Partner in GENERAL DEFINITIONS is deleted and replaced as follows:

"Domestic Partner" means the partner of the Insured who:

1. is a mentally competent adult as is the Insured;
2. has been legally domiciled with the Insured for at least 12 months;
3. is not legally married to or legally separated from another individual;
4. is the sole partner of the Insured and expects to remain so; and
5. is jointly responsible with the Insured for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property.

Licensed independent practice dental hygienist is added to the definition of Physician in GENERAL DEFINITIONS.

The reference to Reasonable and Customary Charges in the MEDICAL EXPENSE BENEFIT is replaced with "actual cost".

The following is added to the MEDICAL EXPENSE BENEFIT:

(6) telemedicine services if the health care service would be covered if provided through in-person consultation between the Insured and the health care provider.

The Proof of Loss provision in CLAIMS PROVISIONS is deleted and replaced as follows:

Proof of Loss: All Proof of Loss under the Policy must be submitted to the Insurer's Claims Administrator as soon as reasonably possible after the date of Loss or insured occurrence.

Notice to Maryland Residents:

QBTP-0001(11-10)-MD

The definitions of Domestic Partner and Emergency Dental Treatment in GENERAL DEFINITIONS are deleted and replaced as follows:

"Domestic Partner" means a person of the same or opposite sex of the Insured who has completed an affidavit that the Insurer requires as described in COMAR 31.10.35.03 C.(3). The Insurer will provide the affidavit upon request. The Insurer also requires one form of proof of common primary residence and one form of proof of financial interdependence between Domestic Partners. The Insurer shall accept any one of the following documents as proof of a common primary residence between Domestic Partners: (1) common ownership of the primary residence via joint deed or mortgage agreement; (2) common leasehold interest in the primary residence; (3) driver's license or State-issued identification listing a common address; or (4) utility or other household bill with both the name of the Insured and the name of the Domestic Partner appearing. The Insurer shall accept any one of the following documents as proof of financial interdependence between Domestic Partners: (1) joint bank account or credit account; (2) designation as the primary beneficiary for life insurance or retirement benefits of the Domestic Partner; (3) designation as primary beneficiary under the Domestic Partner's will; (4) mutual assignments of valid durable powers of attorney under Estates and Trusts Article, 13-601, Annotated Code of Maryland; (5) Mutual valid written advanced directives under Health-General Article, 5-601 et seq., Annotated Code of Maryland, approving the other Domestic Partner as health care agent; (6) joint ownership or holding of investments; or (7) joint ownership or lease of a motor vehicle.

"Emergency Dental Treatment" means required dental care provided to alleviate pain, alleviate the inability to eat or to treat an acute dental condition which presents an immediate and serious threat to the Insured.

The definition of Medically Necessary in GENERAL DEFINITIONS is deleted and shall not apply and all references to the term are deleted.

The definition of Physician in GENERAL DEFINITIONS is amended to include nurse midwife, certified nurse practitioner, nurse anesthetist and licensed certified social worker.

The Excess Insurance Provision in LIMITATIONS is deleted and shall not apply.

All references to Sickness in the MEDICAL EXPENSE BENEFIT are deleted and shall not apply.

The following are added to the MEDICAL EXPENSE BENEFIT:

(6) Outpatient charges for blood products, both derivatives and components, for a covered Injury.

(7) Charges for a corresponding outpatient service that is provided to the Insured instead of an inpatient service in an acute general Hospital because of the denial, after review under a utilization review program, of a request by the attending Physician for an inpatient admission.

(8) Charges for general anesthesia and associated Hospital or ambulatory facility charges in conjunction with dental care provided to an Insured if he:

1. (i) is 7 years of age or younger or is developmentally disabled;

(ii) is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition; and

(iii) is an individual for whom a superior result can be expected from dental care provided under general anesthesia; or

2. (i) is an extremely uncooperative, fearful, or uncommunicative child who is 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred; and

(ii) is an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

Coverage for general anesthesia and associated Hospital or ambulatory facility charges is restricted to dental care that is provided by:

a. a fully accredited specialist in pediatric dentistry;

b. a fully accredited specialist in oral and maxillofacial surgery; and

c. a dentist to whom Hospital privileges have been granted.

This benefit does not cover dental care rendered for temporomandibular joint disorders.

Exclusion (4) in GENERAL EXCLUSIONS pertaining to War shall not apply to acts of terrorism.

Exclusion (8) is in GENERAL EXCLUSIONS is deleted and replaced as follows:

(8) Loss to which a contributing cause was the Insured's commission of or attempt to commit a felony, or being engaged in an illegal occupation;

Exclusion (9) in GENERAL EXCLUSIONS pertaining to "Mental, Nervous…" is deleted and shall not apply

Exclusion (11) is in GENERAL EXCLUSIONS is deleted and replaced as follows:

(11) Loss sustained or contracted in consequence of the Insured being Intoxicated or under the influence of any narcotic except as prescribed by a Physician;

Exclusion (16) pertaining to "…Medically Necessary" is deleted and shall not apply.
The "Payment of Claims: When Paid" provision in CLAIMS PROVISIONS is deleted and replaced as follows:

Payment of Claims: When Paid: Claims for benefits due will be paid not more than 30 days after the Insurer's claims administrator receives due written Proof of Loss.

The Conformity With Laws provision in GENERAL PROVISIONS is deleted and replaced as follows:

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

Notice to Massachusetts Residents:

QBTE-0001(11-10)-MA

The definition of Medically Necessary appearing in the GENERAL DEFINITIONS is deleted and all references to the term are deleted and shall not apply.

The definition of Physician appearing in the GENERAL DEFINITIONS is amended to include a psychotherapist, optometrist, podiatrist, certified nurse midwife, nurse anesthetist and nurse practitioner.

The definition of Sickness appearing in the GENERAL DEFINITIONS is deleted and all references to the term are deleted and shall not apply.

The following is added to the MEDICAL EXPENSE BENEFIT:

(6 Charges for chiropractic services;

(7) Charges for emergency care provided for a Medical Emergency;

"Medical Emergency" means a condition caused by an Injury 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.

(8) Charges incurred for Home Care Services. As used in this benefit "Home Care Services" mean health care services for a patient provided by a public or private home health agency which meets the standards of service of the purchaser of service, provided in a

patient's residence; provided, however, that such residence is neither a Hospital nor an institution primarily engaged in providing skilled nursing or rehabilitation services. Such services shall include, but not be limited to, nursing and physical therapy. Additional services such as occupational therapy, speech therapy, medical social work, nutritional consultation, the services of a home health aid and the use of durable medical equipment and supplies shall be provided to the extent such additional services are determined to be a necessary component of such nursing and physical therapy. Benefits for home care services shall apply only when such services are necessary and provided in conjunction with a Physician approved home health services plan.

The Payment of Claims: When Paid provision in CLAIMS PROVISIONS is deleted and replaced as follows:

Benefits for Loss covered by the Policy will be paid as soon as the Insurer's claims administrator receives proper written proof of such loss. Within 45 days from such receipt of proof of loss if payment is not made they shall notify the claimant in writing specifying the reasons for the nonpayment or whatever further documentation is necessary for payment of such claim within the terms of the Policy. If they fail to comply with this provision, they shall pay, in addition to any benefits which inure to such claimant or provider, interest on such benefits, which shall accrue beginning 45 days after their receipt of proof of loss at the rate of 1 ½% per month, not to exceed 18% per year. The provisions of this paragraph relating to interest payments shall not apply to a claim which the Insurer's claims administrator is investigating because of suspected fraud.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.
The following notice is added:

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Notice to Michigan Residents:

QBTE-0001(11-10)-MI

The following is added to the MEDICAL EXPENSE BENEFIT:

(6) Medical Emergency treatment to the point of Stabilization. The Insurer will not deny payment for services provided for Medical Emergency treatment up to the point of Stabilization because of either of the following: (a) the final diagnosis; or (b) prior authorization was not given by the Insurer before such services were provided.

"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.

"Stabilization" means the point at which no material deterioration of a Medical Emergency requiring Medical Emergency treatment is likely, within reasonable medical probability, to result from or occur during transfer of the patient.

In the Legal Actions provision in GENERAL PROVISIONS, "3 years" is replaced with "6 years".

Notice to Minnesota Residents:

QBTE-0001(11-10)-MN

The following is added to the face page:

THIS IS A NON-QUALIFIED PLAN

LIMITED BENEFIT PLAN READ IT CAREFULLY

Exclusions (8) and (11) are deleted and replaced with the following:

(8) The Insurer shall not be liable for any loss 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's being engaged in an illegal occupation.

(11) The Insurer shall not be liable for any loss sustained or contracted in consequence of the Covered Person's being under the influence of any narcotic unless administered on the advice of a Physician.

The Subrogation provision in CLAIMS PROVISIONS is deleted and replaced by the following:

Subrogation: If an Insured makes a claim against a collateral source for damages that include repayment for medical and medically related expenses incurred for the Insured's benefit, the Insured shall provide timely notice, in writing, to the Insurer of the pending or potential claim.

If the Insurer has paid benefits to an Insured for an Injury and the Insured has also received a full recovery from another source, the Insurer shall have subrogation rights to the extent of its payment, subject to subtraction for actual monies paid to account for the pro rata share of the Insured's costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining such recovery unless the Insurer is separately represented by an attorney. If the Insurer is separately represented by an attorney, it and the Insured, by its attorneys, may enter into an agreement regarding allocation of the Insured's expenses. If the Insurer cannot reach agreement on allocation, The Insurer and the Insured shall submit the matter to binding arbitration. Nothing in this provision shall limit the Insurer's right to recovery from another source which may otherwise exist at law.

However, the Insurer does not have these subrogation rights in the case where the other source is a person or organization also insured under this Policy or under any other policy issued by it with respect to the same loss.

The Notice of Claim provision within the Claims Provisions is amended by the addition of the following:

Notification to the Insurer's agent is also acceptable for providing Notice of Claim.

Notice to Missouri Residents:

QBTE-0001(11-10)-MO

The definition of Injury in the GENERAL DEFINITIONS is deleted and replaced with the following:

"Injury" means bodily injury caused by an accident occurring while the Policy is in force as to the person whose injury is the basis of the claim which results in a covered Loss. The injury must be verified by a Physician.

The Excess Insurance provision appearing in the LIMITATIONS is deleted and shall not apply.

The following is added to the MEDICAL EXPENSE BENEFIT:(6) All services performed at a duly licensed ambulatory surgical center which are covered as a Hospital inpatient benefit, are within the scope of the license of the ambulatory surgical center and would normally require hospitalization rather than office or clinic care.

The Payment of Claims: When Paid provision appearing in the CLAIMS PROVISIONS is deleted and replaced with the following:

Payment Of Claims: When Paid: All benefits payable under the Policy shall be payable not more than 30 days after receipt of Proof of Loss. Subject to due Proof of Loss, all accrued benefits payable under the Policy for loss of time shall be paid not less frequently than monthly during the continuance of the period for which the Insurer is liable, and that any balance remaining unpaid at the termination of such period shall be paid as soon as possible after receipt of such proof.

Benefits payable to the Insured will be paid with or without an assignment from the Covered Person to public Hospitals or clinics for Covered Medical Expenses provided to a Covered Person if a proper claim is submitted by the public Hospital or clinic. No benefits will be paid to the public Hospital or clinic if such benefits have been paid by the Covered Person prior to the Insurer's receipt of the claim from the public Hospital or clinic. Payment of benefits to such public Hospital or clinic will discharge the Insurer from all liability to the extent of any such payment.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

The Subrogation provision appearing in the CLAIMS PROVISIONS is deleted and shall not apply.

Notice to Montana Residents:

QBTP-0001(11-10)-MT

The definitions of Complications of Pregnancy and Normal Pregnancy or childbirth in GENERAL DEFINITIONS are deleted, along with all references to those terms, and shall not apply.

The definition of Medically Necessary in GENERAL DEFINITIONS is deleted, along with all references to this term, and shall not apply. Benefits will not be subject to a determination of medical necessity.

The Excess Insurance provision in LIMITATIONS is deleted and shall not apply.

Exclusion (1) in GENERAL EXCLUSIONS pertaining to pregnancy is deleted and shall not apply.

The Payment of Claims: To Whom Paid provision in CLAIM PROVISIONS is deleted and replaced with the following:

Payment of Claims: To Whom Paid: Benefits are payable to the Insured who applied for coverage and paid any required plan cost. Any benefits payable after that Insured's death, will be paid to the survivors of the first surviving class of those that follow:

(1) to his/her spouse, if living. If no living spouse, then

(2) in equal shares to his/her living Children. If there are none, then

(3) in equal shares to his/her living parents. If there are none, then

(4) in equal shares to his/her living brothers and sisters. If there are none, then

(5) to the Insured's estate.

The Subrogation provision in CLAIMS PROVISIONS is deleted and replaced as follows:

Subrogation: The Insurer will first pay all benefits due to an Insured. Then, if any payments for benefits were because of a Loss caused by a Third Party's wrongful act or negligence, the Insurer, to the extent of that payment, will be subrogated to any recovery or right of recovery the Insured has against that Third Party, provided:

(a) The Insured received payment for services as a result of a third party settlement or court judgment; and

(b) Such settlement or judgment specified an amount or portion of payment that represents payment for such benefits; and

(c) The Insurer has paid benefits to the Insured under the Policy for the same services or benefits covered by the settlement or judgment.

To the extent necessary for reimbursement of benefits paid to or on behalf of an Insured, the Insurer is entitled to subrogation against a judgment or recovery received by the Insured from a Third Party found liable for a wrongful act or omission that caused the Injury necessitating benefit payments.

If the Insurer exercises its rights under this provision, it will recover no more than the amount paid under the Policy for such benefits, and it will not begin until the Insured has been fully compensated for their Loss.

If an Insured intends to institute an action for damages against a Third Party, he shall give the Insurer reasonable notice of his intention to institute the action. The Insured may request that the Insurer pay a proportionate share of the reasonable costs of the Third Party action, including attorney fees. The Insurer may elect not to participate in the cost of the action. If such an election is made, the Insurer waives 50% of its subrogation rights.

The Insured will execute and deliver such instruments and papers which may be needed to secure the rights described above.

"**Third Party**" means any person or organization other than the Insurer or the Insured.

This provision will not apply if it is prohibited by law.

The Conformity with State Laws provision appearing in GENERAL PROVISIONS is deleted and replaced as follows:

Conformity With Montana Statutes: The provisions of the Policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the Insured resides on or after the effective date of the Policy.

Notice to Mississippi Residents:
QBTE-0001(11-10)-MS

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

The Subrogation provision in the CLAIMS PROVISIONS shall not apply until the Insured is made whole for his or her Loss.

The Payment Of Claims: When Paid provision in CLAIMS PROVISIONS is deleted and replaced as follows:

Payment of Claims: When Paid: All benefits payable under the Policy for any Loss will be paid within 25 days after receipt of due written proof of such Loss in the form of a Clean Claim where claims are submitted electronically, and will be paid within 35 days after receipt of due written proof of such Loss in the form of a Clean Claim where claims are submitted in paper format. Benefits due under the Policy and claims are overdue if not paid within 25 days or 35 days, whichever is applicable, after the Insurer's claims administrator receives a Clean Claim containing necessary medical information.

A ***"Clean Claim"*** means a claim received by the Insurer's claims administrator for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the Insured in order to be processed and paid by them. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A Clean Claim includes resubmitted claims with previously identified deficiencies corrected.

A ***"Clean Claim"*** does not include any of the following:

(a) A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within 30 days of the original claim;

(b) Claims which are submitted fraudulently or that are based upon material misrepresentations;

(c) Claims submitted by a provider more than 30 days after the date of service; if the provider does not submit the claim on behalf of the Insured, then a claim is not clean when submitted more than 30 days after the date of billing by the provider to the Insured;

Not later than 25 days after the date the Insurer's claims administrator actually receives an electronic claim, they shall pay the appropriate benefit in full or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to

adjudicate the claim as clean. Not later than 35 days after the date the Insurer's claims administrator actually receives a paper claim, they shall pay the appropriate benefit in full or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the Insurer shall be paid within 20 days after receipt.

For purposes of this provision, the term "pay" means that the Insurer's claims administrator shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the provider or the Insured.

If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed above, the Insurer's claims administrator shall pay the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) interest on accrued benefits at the rate of 1-½ % per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than $1.00, such amount shall be credited to the account of the person or entity to whom such amount is owed.

In the event the Insurer's claims administrator fails to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest which may accrue as provided above and any other damages as may be allowable by law.

The Legal Actions provision in GENERAL PROVISIONS is amended by replacing 60 days with 45 days.

Notice to Nebraska Residents:
QBTE-0001(11-10)-NE

Exclusion (8) appearing in the GENERAL EXCLUSIONS, pertaining to unlawful acts, is replaced with the following:

(8) Any Loss to which a contributing cause was the Insured's commission of, or attempt to commit, a felony or to which a contributing cause was the Insured's being engaged in an illegal occupation.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

The Subrogation provision in the CLAIMS PROVISIONS shall only apply after the Insured is fully compensated.

Notice to Nevada Residents:
QBTE-0001(11-10)-NV

The the definition of Medically Necessary in GENERAL DEFINITIONS is deleted and replaced as follows:

"Medically Necessary" means health care services or products that a prudent Physician would provide to a patient to prevent, diagnose or treat an Injury or Sickness, or any symptoms thereof, that are necessary and:

(1) provided in accordance with generally accepted standards of medical practice;

(2) clinically appropriate with regard to type, frequency, extent, location and duration;

(3) not primarily provided for the convenience of the patient, Physician or other provider of health care;

(4) required to improve a specific health condition of a patient or to preserve his existing state of health; and

(5) the most clinically appropriate level of health care that may be safely provided to the patient.

The following is added to the MEDICAL EXPENSE BENEFIT:

(6) Charges of a Home Health Care Agency for the Medically Necessary treatment and care under a Home Health Care Plan for health supportive services when such services are provided in lieu of continued Hospital confinement. Up to 4 consecutive hours in a 24 hour period of home health care services are considered as one home health care visit. Benefits are limited to 60 visits in any one policy year.

"Home Health Care Agency" means an entity licensed by state or local law operated primarily for the purpose of providing skilled nursing care and therapeutic services in a person's home and: a) which maintains clinical records on each patient; b) whose services are under the supervision of a physician; and c) which maintains operational policies established by a professional group including at least one physician and one nurse.

"Home Health Care Plan" means a program for continued care and treatment of a person. It must be established and approved in writing by the Physician. Care under the Plan must begin within 14 days after Hospital confinement for the same Injury [or Sickness]. An attending Physician must certify that proper treatment of the Injury [or Sickness] would require continued confinement in a Hospital in the absence of the services and supplies as a part of the Plan.

Exclusion (11) in the GENERAL EXCLUSIONS pertaining to Loss incurred due to the use of drugs, narcotics or alcohol is deleted and shall not apply.

The Payment of Claims: When Paid provision in the CLAIMS PROVISIONS is deleted and replaced with the following:

Payment of Claims: When Paid: The Insurer's claims administrator will approve or deny all claims within 30 days after satisfactory written Proof of Loss is received. The claim will be paid within 30 days after it is approved. If it is not paid within this time, interest will be paid on the claim at the rate of interest established pursuant to NRS 99-040 unless a different rate of interest is established pursuant to an express written contract between the Insurer and the provider. The interest will be calculated from the date the payment was due until the claim is paid.

If the Insurer's claims administrator needs additional information to determine whether to approve or deny the claim, You will be sent a written notice within 20 days of receipt of proof of loss, explaining why more time is needed. The provider of the health care, if applicable, will also be notified of the reason for the delay. In this case, the decision on the claim will then be made within 30 days of receipt of the additional information. If the claim is approved it will be paid within 30 days after the additional information is received. If it is not paid within this time interest on the claim will be paid as stated in the preceding paragraph.

Notice to New Jersey Residents:
QBTE-0001(11-10)-NJ

The definition of Domestic Partner appearing in the GENERAL DEFINITIONS is deleted and all references to Domestic Partner are replaced with "Civil Union Partner".

The following are added to the GENERAL DEFINITIONS:

"Civil Union" means the legally recognized union of two eligible individuals of the same sex established pursuant to New Jersey law. Parties to a Civil Union shall receive the same benefits and protections and be subject to the same responsibilities as spouses in a marriage.

"Civil Union Partner" means a person who has established a Civil Union pursuant to New Jersey law.

The definition of Sickness appearing in the GENERAL DEFINITIONS is deleted and all references to the term are deleted and shall not apply.

The Excess Insurance provision appearing in the LIMITATIONS is deleted and shall not apply.

Exclusion (4) appearing in the GENERAL EXCLUSIONS pertaining to war or act of war, military duty or riot or insurrection is deleted and replaced with the following:

(4) (a) as a result of war or an act of war, if the loss occurs while serving in the military, naval or air forces of any country, combination of countries or international organization; and (b) as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the loss occurs while serving in such forces and are outside the home area. (The Insurer will refund the pro rata portion of any premium paid for a Covered Person while in the armed forces on active duty. Written notice must be given to the Insurer within 12 months of the date the Insured enters the armed forces.) (c) as a result of war or an act of war while serving in any civilian non-combatant unit supporting or accompanying any military, naval or air forces of any country, combination of countries or international organization; and (d) as a result of the special hazards incident to service in any civilian non-combatant unit supporting or accompanying such forces, provided the loss occurs while serving in such unit and are outside the home area; or (e) active participation in a riot, or insurrection.

Exclusion (8) pertaining to unlawful acts and Exclusion (11) pertaining to the use of drugs, narcotics or alcohol appearing in the GENERAL EXCLUSIONS are deleted and replaced with the following:

(8) loss to which a contributing cause was the Insured's commission of or attempt to commit a felony, or to which a contributing cause was their being engaged in an illegal occupation.

(11) loss sustained or contracted in consequence of the Insured being intoxicated, as defined in the jurisdiction where the accident took place, or under the influence of any narcotic unless administered on the advice of a Physician.

The Claim Forms provision in CLAIMS PROVISIONS is amended to include the following at the end:

If the claimant does not receive the claim forms within 15 days, the claimant will satisfy the requirements of written proof of loss by sending the written (or authorized electron-

ic or telephonic) proof within the time period shown in the proof of Loss provision.

The Payment of Claims: When Paid provision in CLAIMS PROVISIONS is amended to include the following at the end:

All claims for MEDICAL EXPENSE BENEFITS shall be filed by the Insured using the standard health care claim form provided by the Insurer's claims administrator.

(1) The Insurer's claims administrator shall remit payment for every insured claim submitted by an Insured no later than the 30th calendar day following receipt of the claim by them or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

(a) the health care provider is eligible at the date of service;

(b) the person who received the health care service was covered on the date of service;

(c) the claim is for a service or supply covered under the Policy;

(d) the claim is submitted with all the information requested by the Insurer's claims administrator on the claim form or in other instructions that were distributed in advance to the Insured; and

(e) They have no reason to believe that the claim has been submitted fraudulently.

(2) If all or a portion of the claim is not paid within the time frames provided in paragraph (1) above because:

(a) the claim submission is incomplete because the required substantiating documentation has not been submitted to the Insurer's claims administrator;

(b) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;

(c) They dispute the amount claimed; or

(d) there is strong evidence of fraud by the provider and the Insurer's claims administrator has initiated an investigation into the suspected fraud,

The Insurer's claims administrator shall notify the Insured in writing within 30 days of receiving an electronic claim, or notify the Insured in writing within

40 days of receiving a claim submitted by other than electronic means, that:

(a) the claim is incomplete with a statement as to what substantiating documentation is required for adjudication of the claim;

(b) the claim contains incorrect information with a statement as to what information must be corrected for adjudication of the claim;

(c) They dispute the amount claimed in whole or in part with a statement as to the basis of that dispute; or

(d) The Insurer's claims administrator finds there is strong evidence of fraud and have initiated an investigation into the suspected fraud in accordance with the Insurer's fraud prevention plan, or referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

(3) Any portion of a claim that meets the criteria established under 1) above shall be paid by the Insurer in accordance with the time limit established under 1).

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

The Subrogation provision appearing in the CLAIMS PROVISIONS is deleted and shall not apply.

The following provision is added to the CLAIMS PROVISIONS as the last provision:

Right to File a Complaint: The Policyholder and any Insured have the right to file a complaint with the New Jersey Department of Banking and Insurance.

Notice to New Mexico Residents:

QBTE-0001(11-10)-NM

The definition of Physician is deleted and replaced with the following:

"*Physician*" means a properly licensed practitioner of the healing arts 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.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

The following is added to the Payment of Claims: To Whom Paid provision in the CLAIMS PROVISIONS:

Benefits paid on behalf of an Insured will be paid to the Human Services Department when:

1. The Human Services Department has paid or is paying benefits on behalf of such person under the state's Medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.;
2. Payment for the services in question has been made by the Human Services Department to the Medicaid provider; and
3. The Insurer is notified that such person receives benefits under the Medicaid program and that benefits must be paid directly to the Human Services Department.

Notice to New York Residents:

QBTE-0001(11-10) - NY

The following section is added to the Cover Page, replacing the sentence referencing refund of premium:

CANCELLATION BY THE INSURED: the Insured has the right to cancel the Policy at any time by giving advance notice to the Insurer's agent or the Insurer (stating when thereafter the cancellation shall be effective). The Insurer will refund any unearned premium to You within 10 days of cancellation.

CANCELLATION BY THE INSURER: This is a single pay, single term, non-renewable Policy. The Insurer have no unilateral right to cancel this Policy after the Effective date of coverage.

The definitions of Domestic Partner and Hospital are deleted and replaced as follows:

"Domestic Partner" means a person who with respect to another person: is formally a party in a domestic partnership or similar relationship with the other person, entered into pursuant to the laws of the United States or any State, local or foreign jurisdiction, or registered as the domestic partner of the other person with any registry maintained by the employer of either party or any State, municipality, or foreign jurisdiction; is dependent or mutually interdependent on the other person for support, as evidenced by the totality of the circumstances indicating a mutual intent to be domestic partners including, but not limited to: common ownership or joint leasing of real or personal property; common house-holding, shared income or shared expenses; children in common; signs of intent to marry or become domestic partners; or the length of the personal relationship of the persons.

"Hospital" means a short-term, acute, general hospital, 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) if located in New York State, 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 1395x[k]);
(6) is duly licensed by the agency responsible for licensing such hospitals; and

is not, 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.

The definition of Medically Necessary is deleted in its entirety.

The second paragraph of Insured's Termination Dates is deleted and replaced as follows:

(a) the scheduled return date as stated on the electronic/paper travel ticket;
(b) the date You return to Your origination point if prior to the scheduled return date as stated on the electronic/paper travel ticket;
(c) the date You leave or change Your Trip (unless due to unforeseen and unavoidable circumstances covered by the Policy;
(d) if You extend the return date, coverage will terminate at 11:59 P.M., local time, at Your location on the scheduled return date as stated on the electronic/paper travel ticket;
(e) the date You cancel Your Trip.

The Excess Insurance provision appearing in LIMITATION is deleted and shall not apply.

The following is added at the end of MEDICAL EXPENSE BENEFITS:
Under New York law, certain mandated benefits are required for coverage. The Insurer will also cover all mandated coverages pursuant to New York law, subject to the same terms and conditions.

GENERAL EXCLUSIONS (4), (8), (9) and (11) are deleted and replaced as follows:

(4) War, or an act of war (whether declared or undeclared);
(8) Expenses as a result of or in connection with the commission of any Delong or attempt to commit a felony or to which a contributing cause was an Insured, Traveling Companion or Family Member being engaged in an illegal occupation;
(9) Mental or nervous disorders, except to the extent required by New York law;
(11) Treatment in connection with alcoholism and drug addition, or use of any drug or narcotic agent, except use of a drug prescribed by a physician to the extent coverage is required by New York law;

Exclusions (2), (15), (16), (17) and (20) are deleted in their entirety.

The Proof of Loss provision in CLAIMS PROVISIONS is deleted and replaced as follows:
The claimant must send the Insurer, or the Insurer's designated representative, Proof of Loss within 120 days after a covered Loss occurs or as soon as reasonably possible.

The Payment of Claims:When Paid provision in CLAIMS PROVISIONS is deleted and replaced as follows:
Benefits under this Policy are payable to the Insured not more than 60 days after receipt of proper Proof of Loss.

The Subrogation provision in CLAIMS PROVISIONS is deleted and shall not apply.

The Legal Actions provision in the GENERAL PROVISIONS is deleted and replaced as follows:
No legal action for a claim can be brought against the Insurer until 60 days after the Insurer receives Proof of Loss. No legal action for a claim can be brought against the Insurer more than 2 years after the time required for giving proof of loss.

The Concealment or Fraud provision in the GENERAL PROVISIONS is deleted and replaced as follows:
Coverage for an Insured shall be void if, whether before or after a loss, the Insured signs a written instrument which conceals or misrepresents any material fact or circumstance concerning the Policy or the subject thereof, or the interest of the Insured therein, or if in such written instrument, the Insured commits fraud or false swearing in connection with any of the foregoing.

Notice to North Carolina Residents:
QBTP-0001(11-10)-NC

The definition of Complications of Pregnancy in GENERAL DEFINITIONS is deleted and replaced as follows:

"Complications of Pregnancy" means:

1. Conditions whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy. Examples are acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. False labor, occasional spotting, Doctor 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 are not considered "complications";
2. Non-elective caesarean section;
3. Ectopic pregnancy which is terminated;
4. Spontaneous termination of pregnancy that occurs under a period of gestation in which a viable birth is not possible.

"Complications of Pregnancy" as defined above are covered under the Policy to the same extent as any other Sickness.

The following definitions are added to the GENERAL DEFINITIONS:

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would cause a prudent lay person, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

(1) Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
(2) Serious impairment to bodily functions; or
(3) Serious dysfunction of any bodily organ or part.

"Emergency Services" means health care items and services furnished or required to screen for or treat an Emergency Medical Condition until the condition is stabilized, including pre-Hospital care and ancillary services routinely available to the emergency department.

The definition of Hospital in GENERAL DEFINITIONS is amended to include the following:

Hospital also includes a duly licensed state tax-supported institution functioning as a specialty facility for treatment of a particular type of illness. Facilities for the performance of surgery are not required.

The Excess Insurance Provision in LIMITATIONS is deleted and shall not apply.

The following are added to the MEDICAL EXPENSE BENEFIT:

(f) Chiropractic care services provided by a chiropractor acting within the scope of his or her license;

(g) Emergency Services provided for an Emergency Medical Condition;

The following is added at the end of the MEDICAL EXPENSE BENEFIT:

NOTICE: The Insured's medical expenses incurred may exceed the stated Medical Expense Benefits because actual provider charges may not be used to determine the Insurer's and the Insured's payment obligations.

Item (4) pertaining to other insurance benefits is deleted from the first paragraph of the DENTAL EXPENSE BENEFIT.

Exclusion (4) in GENERAL EXCLUSIONS pertaining to war is amended to include the following at the end:

However, this exclusion does not apply to terrorism.

Exclusion (11) in GENERAL EXCLUSIONS pertaining to use of drugs is deleted and does not apply.

The Payment of Claims: When Paid: provision in CLAIMS PROVISIONS is amended to include the following at the end:

Within 30 calendar days after the Insurer's claims administrator receive due written proof of loss, they will send by electronic or paper mail to the claimant, payment, notice of why the claim is denied or notice of additional information needed.

The Payment of Claims: To Whom Paid: provision in CLAIMS PROVISIONS is amended to include the following as the last paragraph:

Subject to the Insured's written direction to the contrary, all or a portion of any Medical Expense Benefits provided by the Policy may, at the Insurer's option, be paid directly to the provider of such services or to any other party legally entitled to such payment under federal or state medical child support laws, or jointly to any one of these. Any such payment made in good faith shall fully discharge the Insurer to the extent of such payment. In no case will the Insurer require that the service be rendered by a particular Hospital or person.

The following is added at the end of the GENERAL PROVISIONS:

NOTICE OF INSURANCE FIDUCIARY RESPONSIBILITIES:

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

Notice to North Dakota Residents:

QBTE-0001(11-10)-ND

The following is added to the MEDICAL EXPENSE BENEFIT:

(f) Charges for pre-Hospital emergency medical services for a medical emergency.

Notice to Ohio Residents:

QBTE-0001(11-10)-OH

The following notice is added to the face page:

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS

AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

The Payment of Claims: When Paid provision in the CLAIMS PROVISIONS is deleted and replaced with the following:

Payment of Claims: When Paid: Benefits for loss covered by the Policy, other than benefits that require periodic payment, will be paid within 30 days after the Insurer's claims administrator receives proper written proof of such loss, subject to Ohio law.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

The Concealment or Fraud provision in GENERAL PROVISIONS is deleted and replaced with the following:

Concealment or Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Residents:

QBTP-0001(11-10)-OK

The following notices are added to the cover page:

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE: The Policyholder has the right to return the Policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the Policy, the Policyholder is not satisfied for any reason. If the Insurer does not return any premiums or money paid therefore within thirty (30) days from the date of cancellation, the Insurer will pay interest on the proceeds.

The definition of Domestic Partner in GENERAL DEFINITIONS is deleted along with all references to the term and does not apply.

The definition of Family Member in GENERAL DEFINITIONS is amended to include "adopted child".

Exclusions (4), (8) and (11) in GENERAL EXCLUSIONS are deleted and replaced as follows:

(4) war or act of war, whether declared or not, while serving in the military or an auxiliary unit thereto or voluntary participation in a civil disorder, riot, or insurrection;

(8) any intentional unlawful acts, committed by the Insured, a Family Member, or a Traveling Companion, or Business Partner whether insured or not;

(11) intentional use of drugs, narcotics, or alcohol, unless administered upon the advice of a Physician;

The Payment of Claims: When Paid provision in CLAIMS PROVISIONS is deleted and replaced as follows:

Payment of Claims: When Paid: The Insurer's claims administrator will pay all Clean Claims of an Insured, their assignee or a health care provider within 45 calendar days after receipt of the claim by them.

"Clean Claim" means a claim for benefits that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment that impedes prompt payment.

If a claim or any portion of a claim is determined to have defects or improprieties, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment the Insurer's claims administrator will notify the Insured, their assignee or health care provider in writing within 30 calendar days after they receive the claim. Their notice will state the portion of the claim that is causing the delay in processing and explain any additional information or corrections needed. Failure to provide this notice will constitute prima facie evidence that the claim will be paid in accordance with the terms of the Policy.

Upon receipt of the additional information or corrections which led to the claim being delayed and a determination that the information is accurate, the Insurer's claims administrator will either pay or deny the claim or a portion of the claim within 45 calendar days.

Payment is considered made on the date a draft or other valid instrument which is equivalent to the amount of the payment is placed in the U.S. mail in a properly addressed, postpaid envelope; or if not so posted, the date of delivery. An overdue payment will bear simple interest at the rate of 10% per year.

Notice to Oregon Residents:

QBTE-0001(11-10)-OR

The following are added to the GENERAL DEFINITIONS:

"Domestic Partnership" means a civil contract entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon.

"Emergency Medical Condition" means a medical condition that manifests itself by acute symptoms of sufficient severity including severe pain that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person or fetus, in the case of a pregnant woman, in serious jeopardy.

The definition of Physician in the GENERAL DEFINITIONS is deleted and replaced as follows:

"Physician" means a licensed practitioner of the healing arts, including accredited Christian Science Practitioners, acting within the scope of his/her license. The treating Physician may not be the Insured, a Traveling Companion, a Family Member, a Business Partner or retained by the Policyholder. Covered services performed by Physician are also paid when referred to a clinical social worker to perform the service. Physician also includes a dentist, certified nurse practitioner, optometrist and physician's assistant.

The Excess Insurance Provision in LIMITATIONS will apply only to the Baggage Benefits and Baggage Delay Benefits.

The following is added to the MEDICAL EXPENSE BENEFIT:

(f) treatment for an Emergency Medical Condition.

Exclusion (4) and (11) in GENERAL EXCLUSIONS are deleted and replaced as follows:

(4) war or act of war, whether declared or not, or the Insured's active participation in a civil disorder, riot, or insurrection; "War" means military activity by one or more national governments and does not include terrorist acts, other random acts of violence not perpetrated by the Insured, civil war, or a local or community faction.

(11) being legally intoxicated according to the laws of the location where the Loss took place or being under the influence of illegal drugs or narcotics according to the laws of the location where the Loss took place, unless such drugs or narcotics are administered upon the advice of a Physician or purchased over the counter.

The Notice of Claim provision within CLAIMS PROVISIONS is deleted and replaced with the following:

Notice of Claim: The Insured must call the Insurer's claims administrator at 1-800-453-4075 within 20 days after the commencement of any Loss or as soon as reasonably possible, and be prepared to describe the Loss, the name of the entity that arranged the Trip, the Trip dates, and the amount that the Insured paid. The Insurer's claims administrator will process the claim.

In Item (2), in the Payment of Claims: To Whom Paid provision in CLAIM PROVISIONS, reference to Domestic Partner is added, and the following is added at the end of this provision:

Payments for covered ambulance services will be paid directly to the provider or jointly to the Insured and the provider.

The Concealment or Fraud provision in GENERAL PROVISIONS is deleted and shall not apply.

Notice to Pennsylvania Residents:

QBTE-0001(11-10)-PA

The following notice is added to the cover page:

NOTICE: If a Covered Person has received medical care or advice within the past 90 days for a disease or physical condition, he or she will not be covered for such disease or physical condition until he or she has been covered for 12 months under this contract. This exclusion, however, only applies to a disease or physical condition for which medical care or advice has been received in the past 90 days.

The following is added at the end of the definition of Physician in the GENERAL DEFINITIONS:

Physician also includes a chiropractor, dentist, osteopath, physical therapist, podiatrist, optometrist, psychologist, nurse midwife, certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse or certified clinical nurse specialist, certified by the Pennsylvania State Board of Nursing or a national nursing organization recognized by the Pennsylvania State Board of Nursing and lawfully permitted to perform a covered service.

The following is added at the end of the Excess Insurance provision appearing in the LIMITATIONS:

the Insurer will pay the first $100 of MEDICAL EXPENSE BENEFITS on a primary basis and then the excess provision will apply on amounts after the first $100.

The following is added to MEDICAL EXPENSE BENEFIT:

(6) Services required to treat a covered accident performed by a Physician, including a chiropractor, dentist, osteopath, physical therapist, podiatrist, optometrist, psychologist, nurse midwife, certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse or certified clinical nurse specialist, certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing and lawfully permitted to perform that service.

The following is added at the end of the Payment of Claims: When Paid provision appearing in the CLAIMS PROVISIONS:

Medical Expense Benefit amounts due under the Policy for a Loss, will be paid not more than 45 days after the Insurer's claims administrator receive dues written Proof of Loss and supporting documentation. Interest of 10% per annum will be added to clean claims not paid within the time limit, beginning with the date the payment is late and ending with the date the claim is paid.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

Notice to Rhode Island Residents:

QBTE-0001(11-10)-RI

The following is added to MEDICAL EXPENSE BENEFIT at the end:

Medical emergency care room and supplies, including the attending Physician's charges, X-rays, laboratory procedures, use of the emergency room and supplies. The first expense must be incurred within 72 hours of an accident, or as soon as reasonably possible. The Payment of Claims: When Paid section in the CLAIMS PROVISIONS is deleted and replaced as follows:

Payment of Claims: When Paid: If benefits are payable, the Insurer's claims administrator will pay the benefits in accordance with the Payment of Claims: To Whom Paid provision within 60 days after such Proof of Loss is received.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

Notice to South Carolina Residents:

QBTE-0001(11-10)-SC

The definition of Physician in GENERAL DEFINITIONS is amended to include a licensed podiatrist, oral surgeon, optometrist, chiropractor and doctoral psychologist.

The following is added to the MEDICAL EXPENSE BENEFIT at the end:

Extension of Benefits: If an Insured is totally disabled on the date insurance terminates, charges incurred for the continuation of that total disability shall also be covered during the 90 day period following the date insurance terminates.

Exclusion (11) pertaining to the use of alcohol, drugs or narcotics in GENERAL EXCLUSIONS is deleted and replaced as follows:

(11) Any Loss resulting from being intoxicated or under the influence of a narcotic unless taken on the advice of a Physician.

The Payment of Claims: When Paid provision in CLAIMS PROVISIONS is amended to reference that claims will be paid not more than 60 days after the Insurer's claims administrator receives complete Proof of Loss.

The Legal Actions provision in GENERAL PROVISIONS is amended to read "6 years".

Notice to South Dakota Residents:

QBTE-0001(11-10)-SD

The following notice is added to the face page:

THE POLICY LIMITS SOME BENEFITS TO REASONABLE AND CUSTOMARY CHARGES AND THIS LIMITATION MAY CAUSE THE INSURED TO INCUR ADDITIONAL OUT-OF-POCKET EXPENSES.

The following is included at the end of the definition of Physician in GENERAL DEFINITIONS:

However, this exclusion of Family Members does not apply in those areas in which the Family Member is the only Physician in the area and is acting within the scope of their normal employment.

The Excess Insurance provision in LIMITATIONS is deleted and shall not apply. All benefits will be paid on a primary basis.

Exclusion (11) in GENERAL EXCLUSIONS pertaining to the Insured being under the influence of alcohol or drugs is deleted and shall not apply.

The following is added to the Payment of Claims: When Paid provision in CLAIM PROVISIONS:

A Clean Claim for Covered Medical Expenses will be paid, denied or settled within 30 calendar days after receipt by the Insurer's claims administrator if submitted electronically and within 45 calendar days otherwise. If additional information is needed on an otherwise Clean Claim they will, within 30 calendar days after receipt, give the claimant a full explanation of what is needed in order to determine eligibility or adjudicate the claim. The person receiving the request for additional information must submit all information requested by the Insurer's claims administrator within 30 calendar days after receipt of the Insurer's request.

"Clean Claim" means a claim for which there is no need for addition information to determine eligibility or adjudicate the claim. It does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law, or a claim for which fraud is suspected.

Notice to Tennessee Residents:

QBTE-0001(11-10)-TN

Exclusion (11) in the GENERAL EXCLUSIONS, pertaining to the use of drugs, narcotics or alcohol, is deleted and replaced with the following:

(11) Loss caused by, contributed to, or resulting from voluntarily: (a) being intoxicated (above the blood alcohol legal limit for operating a motor vehicle in the jurisdiction where the Loss occurred); (b) being under the influence of illegal drugs; or (c) taking prescription drugs or medicines, except as prescribed by a Physician.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

The Subrogation provision in the CLAIMS PROVISIONS is deleted and replaced as follows:

Right of Recovery: An Insured may incur charges due to an Injury for which benefits are paid by this Policy. The Injury may be caused by the act or omission of another person. If so, the Insured may have a claim against that other person for payment of expense-incurred charges. If Recovery under the claim is made and the Insured has been fully compensated for actual damages, the Insured must Refund the Insurer the Recovery made from 1) the other person; or 2) the other person's insurer up to the amount of benefits the Insurer actually paid under the Policy for such Injury.

Only the amount recovered for medical expenses incurred will be subject to Refund. In no case will the amount of Refund exceed the amount of benefits the Insurer paid for the Injury under the Policy. The right of Refund also applies when the Insured recovers under an uninsured or underinsured motorist plan.

"Recovery" means monies paid to the Insured through judgment, settlement or otherwise to compensate for all Losses caused by the Injury.

"Refund" means repayment to the Insurer for benefits paid under the Policy for the Injury.

Notice to Texas Residents

QBTE-0001(11-10)-TX

The following is added to the definition of Physician in GENERAL DEFINITIONS:

"Physician" includes, but is not limited to, an acupuncturist, advanced practice nurse, audiologist, chemical dependency counselor, chiropractor, dentist, dietitian, hearing instrument fitter and dispenser, licensed clinical social worker, licensed professional counselor, marriage

and family therapist, occupational therapist, optometrist, physical therapist, physician, physician assistant, podiatrist, psychological associate, psychologist, speech-language pathologist and surgical assistant.

The definition of Sickness in GENERAL DEFINITIONS is deleted and replaced as follows:

"Sickness" means an illness, disease or condition of the Insured that causes a loss for which an Insured incurs medical expenses. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

The following are added to the MEDICAL EXPENSE BENEFIT:

(f) Emergency Medical Treatment.

"Emergency Medical Treatment" means health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition or Injury is of such a nature that failure to get immediate medical care could result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment of bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

(g) Telehealth Service and Telemedicine Service.

"Telehealth Service" means a health service other than a Telemedicine Medical Service, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. Compressed digital interactive video, audio, or data transmission;
2. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
3. Other technology that facilitates access to health care services or medical specialty expertise.

"Telemedicine Medical Service" means a health care service initiated by a Physician or provided by a

health professional acting under Physician delegation and supervision for purposes of patient assessment by a health professional, diagnosis or consultation by a Physician, treatment, or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. Compressed digital interactive video, audio, or data transmission;
2. Clinical data transmission using computer imaging by way of still-image capture; and
3. Other technology that facilitates access to health care services or medical specialty expertise.

It also:

1. means medical services delivered by telecommunications technologies to rural or underserved public not-for-profit health care facilities or primary health care facilities in collaboration with an academic health center and an associated teaching hospital or tertiary center or with another public not-for-profit health care facility; and
2. includes consultative services, diagnostic services, interactive video consultation, teleradiology, telepathology, and distance education for working health care professionals.

(h) Treatment, including Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation, Neurobehavioral, Neurophysiological, Neuropsychological, and Psychophysiological Testing or Treatment, Neurofeedback Therapy, Remediation, Post-acute Transition Services, or Community Reintegration Services necessary as a result of and related to an Acquired Brain Injury due to an Injury under the Policy.

"Acquired Brain Injury" means neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

"Cognitive Communication Therapy" means services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

"Cognitive Rehabilitation Therapy" means services designed to address therapeutic cognitive activities,

based on an assessment and understanding of the individual's brain-behavioral deficits.

"Community Reintegration Services" means services that facilitate the continuum of care as an affected individual transitions into the community.

"Neurobehavioral Testing" means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior.

"Neurobehavioral Treatment" means interventions that focus on behavior and the variables that control behavior.

"Neurocognitive Rehabilitation" means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

"Neurocognitive Therapy" means services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

"Neurofeedback Therapy" means services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

"Neurophysiological Testing" means an evaluation of the functions of the nervous system.

"Neurophysiological Treatment" means interventions that focus on the functions of the nervous system.

"Neuropsychological Testing" means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

"Neuropschological Treatment" means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

"Post-acute Transition Services" means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

"Psychophysiological Testing" means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

"Psychophysiological Treatment" means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

"Remediation" means the process(es) of restoring or improving a specific function.

The Payment of Claims: When Paid provision in CLAIMS PROVISIONS is deleted and replaced as follows:

RECEIPT OF NOTICE OF CLAIM.

(a) Not later than 15 days from the date the Insurer's claims administrator receives Notice of Claim, they shall:

(1) acknowledge receipt of the claim;

(2) commence any investigation of the claim; and

(3) request from the claimant all items, statements, and forms that they reasonably believe, at that time, will be required from the claimant.

(b) They may make additional requests for information if during the investigation of the claim the additional requests are necessary.

(c) If the acknowledgment of receipt of a claim is not made in writing, They shall make a record of the date, manner, and content of the acknowledgment.

NOTICE OF ACCEPTANCE OR REJECTION OF CLAIM.

(a) Except as provided by (b) or (d) below, the Insurer's claims administrator shall notify a claimant in writing of the acceptance or rejection of a claim not later than the 15th business day after the date they receive all items, statements, and forms required by the Insurer to secure final proof of loss.

(b) If they have a reasonable basis to believe that a loss resulted from arson, they shall notify the claimant in writing of the acceptance or rejection of the claim not later than the 30th day after the date they receive all items, statements, and forms required by the Insurer.

(c) If they reject the claim, the notice shall state the reasons for the rejection.

(d) If they are unable to accept or reject the claim within the period specified by (a) or (b) above, they, within that same period, shall notify the claimant of the reasons that they need additional time. They shall accept or reject the claim not later than the 45th day after the date they notify a claimant under this provision.

PAYMENT OF CLAIM.

(a) Except as otherwise provided by this provision, if the Insurer's claims administrator notifies a claimant that they will pay a claim or part of a claim, they shall pay

the claim not later than the fifth business day after the date notice is made.

(b) If payment of the claim or part of the claim is conditioned on the performance of an act by the claimant, they shall pay the claim not later than the fifth business day after the date the act is performed.

DELAY IN PAYMENT OF CLAIM.

(a) Except as otherwise provided, if the Insurer's claims administrator, after receiving all items, statements, and forms reasonably requested and required, delays payment of the claim for a period exceeding the period specified by other applicable provision or, if other provisions do not specify a period, for more than 60 days, they shall pay damages and other items as provided below.

(b) Item (a) above does not apply in a case in which it is found as a result of arbitration or litigation that a claim received by the Insurer's claims administrator is invalid and should not be paid by them.

EXTENSION OF DEADLINES.

(a) A court may grant a request by a guaranty association for an extension of the periods under this provision on a showing of good cause and after reasonable notice to policyholders.

(b) In the event of a weather-related catastrophe or major natural disaster, as defined by the Commissioner of Insurance, the claim-handling deadlines imposed under this provision are extended for an additional 15 days.

LIABILITY FOR VIOLATION.

(a) If the Insurer is liable for a claim under the Policy and are not in compliance with these claim payment provisions, the Insurer's claims administrator is liable to pay the Insured or the beneficiary making the claim under the Policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.

(b) If a suit is filed, the attorney's fees shall be taxed as part of the costs in the case.

REMEDIES NOT EXCLUSIVE.

The remedies provided above are in addition to any other remedy or procedure provided by law or at common law.

The following is added to the Payment of Claims: To Whom Paid provision in CLAIMS PROVISIONS:

Medical Expense Benefits will be payable to the Texas Department of Human Services if any of the following conditions exist:

1. The Insured has executed an assignment of benefits by reason of making application for or receiving benefits for medical assistance under the Medical Assistance Act of 1967 of the State of Texas, as amended;

2. The Insured is a parent of a covered dependent child and is:

   a. A possessory conservator of said child under an order issued by a Texas court or is not entitled to possession or access to said child; and

   b. Required by court order or court approved agreement to pay child support; or

3. The Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 or 32 of the Human Resources Code.

The Insurer must receive written notice of any of the above conditions and the assignment created by them by an attachment to the claim form originally submitted for benefits under the Policy.

Benefits for a covered dependent child may be paid on behalf of the child to a person who is not the Insured if an order issued by a court of competent jurisdiction in Texas names such person the managing conservator of the child. Such benefits will be payable to the managing conservator provided the conservator has submitted:

1. Written notice to the Insurer with the claim application that such person is the covered Dependent child's managing conservator; and

2. A certified copy of a court order establishing the person as managing conservator or other evidence designed by rule of the State Board of Insurance that such person qualifies to be paid the benefits.

Such requirements shall not apply in the cases of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the Insured where the Insured has paid any portion of a medical bill that would be covered under the terms of the Policy.

Any payment made in good faith and compliance with Texas regulations regarding payment of benefits for medical services shall fully discharge the Insurer to the extent of such payment.

The following is added to the ADDITIONAL CLAIMS PROCEDURES in CLAIMS PROVISIONS, applicable to Baggage and Baggage Delay only:

Disagreement Over Size of Loss. If there is a disagreement about the amount of the loss either the Insured or the Insurer can make a written demand for an appraisal. Within 15 days after the demand, the Insured and the Insurer shall each select their own competent ap-

praiser. Within 15 days after examining the facts, each of the two appraisers will give an opinion on the amount of the loss. If they do not agree, they will select an arbitrator within 15 days. Any figure agreed to by 2 of the 3 (the appraisers and the arbitrator) will be binding. The appraiser selected by the Insured is paid by the Insured. The Insurer will pay the appraiser it chooses. The Insured will share with the Insurer the cost for the arbitrator and the appraisal process.

The Legal Actions provision in GENERAL PROVISIONS is deleted and replaced with the following:

Legal Actions. No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of 2 years and one day from the date the cause of action first accrues. A cause of action first accrues on the date of the initial breach of the Insurer's contractual duties alleged in the action.

QBTR-0002(11-20)-TX

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call the Company's toll-free telephone number for information or to make a complaint at:

1-800-772-6771

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
FAX# (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telephono gratis de Company's para informacion o para informacion o para someter una queja al:

1-877-772-6771

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
FAX# (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Notice to Utah Residents:

QBTE-0001(11-10)-UT

The following notice is added to the face page:

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY OR CONTRACT. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company. [30 days to examine policy]

The definitions of Hospital and Medically Necessary appearing in the GENERAL DEFINITIONS are deleted and replaced with the following:

"Hospital" means a facility duly licensed and operating within the scope of such license.

"Medically Necessary" means a treatment, service or supply that is required to diagnose or treat a covered loss based on generally accepted current medical practice.

The Excess Insurance provision appearing in the LIMITATIONS is deleted and shall not apply.

The following is added to the MEDICAL EXPENSE BENEFIT:

(f) treatment of a Medical Emergency, including any evaluation, diagnostic test, or other covered treatment

considered Medically Necessary to stabilize the Medical Emergency condition.

*"**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 at a Hospital emergency department would place the health of the person in serious jeopardy.

Exclusion (4) in the GENERAL EXCLUSIONS pertaining to participation in civil disorder, riot, insurrection or unlawful acts shall only apply if the Insured's participation was voluntary.

The following is added at the end of the Notice of Claim provision in CLAIMS PROVISIONS:

Failure to give notice within such time shall not invalidate nor reduce any claim if it shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. Failure to give such notice as required does not bar recovery under the Policy if the Insurer fails to show it was prejudiced by the failure.

The following is added at the end of the Proof of Loss provision in CLAIMS PROVISIONS:

Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible. Failure to file Proof of Loss as required does not bar recovery under the policy if the Insurer fails to show it was prejudiced by the failure.

The following is added at the end of the Payment of Claims: When Paid provision in CLAIMS PROVISIONS:

The Insurer's claims administrator shall notify the Insured of the Insurer's benefit decision within 30 days of receipt of Proof of Loss. If the Insurer is unable to make a decision within that time due to circumstances beyond its control, such as late receipt of medical records, the Insurer's claims administrator shall notify the Insured before expiration of the original 30 days that the Insurer intends to extend the time and then it may take as long as 15 additional days to reach a decision. If the extension is due to failure of the Insured to submit necessary information, the extension notice of delay shall give specific information about what the Insured has to provide and the Insured shall be given 45 days to submit the requested information.

The Insurer's claims administrator shall provide notification to the Insured which includes:

1) the specific reason or reasons for the benefit determination, adverse or not;

2) reference to the specific policy provisions on which the benefit determination is based:

3) a description of any additional information necessary for the Insured to perfect the claim and an explanation of why such material or information is necessary; and

4) a description of the Insurer's review procedures and the time limits applicable to such procedures, including a statement of the Insured's right to bring civil action.

All benefits shall be paid as soon as the Insurer's claims administrator receives proper Proof of Loss. Interest will be paid on amounts that are not paid within the time limits specified by Utah law.

The following provisions are added at the end of the CLAIMS PROVISIONS:

Errors Related to Your Coverage: The Insurer has the right to correct benefit payments that are made in error. The Insured has the responsibility to return any overpayments to the Insurer. The Insurer has the responsibility to make additional payments if any underpayments have been made.

Adverse Benefit Determination Review Process

An Insured may submit an Adverse Benefit Determination to the Insurer and it shall conduct an internal review of the Insured's Adverse Benefit Determination. An Insured who disagrees with the results of an internal review may submit the Adverse Benefit Determination for an Independent Review if the Adverse Benefit Determination involves payment of claim regarding Medically Necessary treatment or denial of a claim regarding Medically Necessary treatment.

"Adverse Benefit Determination" means the:

(a) denial of a benefit;

(b) reduction of a benefit;

(c) termination of a benefit; or

(d) failure to provide or make payment, in whole or in part, for a benefit.

"Adverse Benefit Determination" includes:

(a) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Insured's eligibility to participate in a plan;

(b) denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit resulting from the application of a utilization review; and

(c) failure to cover an item or service for which benefits are otherwise provided because it is determined to

be: (a) experimental/investigational treatment; or (b) not Medically Necessary treatment or appropriate.

"Independent Review" means a process that:

(a) is a voluntary option for the resolution of an Adverse Benefit Determination;

(b) is conducted at the discretion of the Insured;

(c) is conducted by an independent review organization designated by the Insurer;

(d) renders an independent and impartial decision on an Adverse Benefit Determination submitted by an Insured; and

(e) may not require the Insured to pay a fee for requesting the Independent Review.

Notice to Vermont Residents:

The definitions of Domestic Partner and Experimental or Investigative are deleted in their entirety.

The definition of physician is amended by the addition of the word "chiropractic".
The second sentence of the definition of sickness is deleted.

The first paragraph of the Insured's Effective Dates provision in INSURED'S EFFECTIVE AND TERMINATION DATES is deleted.

The Insured's Termination Dates provision in INSURED'S EFFECTIVE AND TERMINATION DATES is deleted and replaced as follows:

The Insured's coverage will end on the earliest of the following:

(a) when he or she arrives at the Return Destination;

(b) on the date he or she returns to/arrives at the Return Destination if prior to the Return Date;

(c) when he or she changes his or her Trip (unless due to unforeseen and unavoidable circumstances covered by the Policy).

The Excess Insurance provision in LIMITATIONS is deleted in its entirety.

The TRIP CANCELLATION AND INTERRUPTION BENEFITS provision in DESCRIPTION OF BENEFITS is deleted in its entirety.

The BAGGAGE BENEFITS provision in DESCRIPTION OF BENEFITS is deleted in its entirety.

GENERAL EXCLUSIONS (1) and (2) are deleted and replaced as follows:

(1) pregnancy, except for Complications of Pregnancy;
(2) illness, treatment or medical condition arising out of:
  (a) war or act of war (whether declared or undeclared); active participation in a riot or insurrection;
  (b) suicide (while sane), attempted suicide or intentionally self-inflicted injury;
  (c) aviation;
  (d) interscholastic sports;

The following exclusions are added to GENERAL EXCLUSIONS:

(21) cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of the covered dependent child which has resulted in a functional defect;

(22) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

(23) care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

(24) treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workmen's compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of Hospitals, laboratories or other institutions; services performed by a member of the Insured's immediate family and services for which no charge is normally made in the absence of insurance;

(25) dental care or treatment;

(26) eye glasses, hearing aids and examination for the prescription or fitting thereof;

(27) rest cures, custodial care, transportation and routine physical examinations;

(28) full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured is not covered due to his or her active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded);

(29) any loss to which a contributing cause was the Insured's commission of or attempt to commit a felony or to which a contributing cause was the Insured's being engaged in an illegal occupation.

The following GENERAL EXCLUSIONS are deleted:
(8), (9), (11), (13), (15), (16) and (19).

The Payment of Claims: When Paid within the CLAIMS PROVISIONS is deleted and replaced with the following:
Payment of Claims: When Paid: Within fifteen (15) working days after receipt by Us of properly executed Proofs of Loss, the Insured shall be advised of the acceptance or denial of the claim by Us. We shall not deny a claim on the grounds of a specific Policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the Insured in writing and Our claim file shall contain a copy of the denial. If a claim is denied for other reasons, and is made by any other means than writing, an appropriate notation shall be made in Our claim file.

If We need more time to determine whether a claim should be accepted or denied, We shall so notify the Insured within fifteen (15) working days after receipt of the Proofs of Loss giving the reasons more time is needed. If the investigation remains incomplete, We shall, thirty (30) working days from the date of the initial notification and every thirty (30) working days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation. The provisions of this provision shall not apply upon filing of suit by the Insured.

We shall not fail to settle claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by Policy provisions.

We shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a Policy time limit,

without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to the Insured thirty (30) working days before the date on which such time limit may expire.

After settlement has been agreed upon, We shall mail payment in amount agreed to the Insured within ten (10) working days, unless a further delay is mandated under an order by a court of competent jurisdiction or required by law.

The Concealment or Fraud provision within GENERAL PROVISIONS is deleted.

QBTV-0002(11-10) – VT
Vermont Mandatory Civil Unions Endorsement
PURPOSE:

Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons. This endorsement is part of and amends the policy, contract or certificate to comply with Vermont law.

DEFINITIONS, TERMS, CONDITIONS AND PROVISIONS:

The definitions, terms, conditions and any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a civil union established according to Vermont law.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family relationships created by a civil union established according to Vermont laws.
"Dependent" means a spouse, a party to a civil union established according to Vermont law, and a child or children (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or civil union established according to Vermont law.

"Child or covered child" means a child (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as "ERISA," controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a civil union in and ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons.

Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under the policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

Notice to Virginia Residents:
QBTE-0001-(11-10)-VA

The following notice is added to the face page:

IMPORTANT NOTICE REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact the Insurer's Administrator at the address and telephone number shown at the bottom of this page. If you are unable to contact or obtain satisfaction from the Insurer's Administrator, you may contact the Virginia State Corporation Commission's Bureau of Insurance, P.O. Box 1157, Richmond Virginia 23218, (804) 371-9691 (local), (800) 552-7945 (VA toll-free), (877) 310-6560 (national toll-free)

The definition of Domestic Partner in GENERAL DEFINITIONS is deleted and replaced as follows, and all references to "spouse" are replaced with "spouse or Domestic Partner":

Domestic Partner means the Insured's same or opposite sex domestic partner or party to a civil union, provided they:

(1) have executed a domestic partner affidavit satisfactory to the Insurer, establishing that the Insured and

their partner are domestic partners or parties to a civil union for purposes of the Policy or;

(2) have registered as domestic partners or parties to a civil union with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.

They will continue to be considered domestic partners or parties to a civil union provided they continue to meet the requirements described in the domestic partner affidavit or required by law.

The definition of Physician in GENERAL DEFINITIONS is deleted and replaced as follows:

"Physician" means a person who is a qualified doctor of medicine, dental practitioner, chiropractor, optometrist, optician, professional counselor, psychologist, clinical social worker, podiatrist, physical therapist, chiropodist, clinical nurse specialist who renders mental health services, audiologist, speech pathologist, certified nurse midwife, marriage and family therapist or licensed acupuncturist. As such, he or she must be acting within the scope of his/her license/certification under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include the Insured or a member of the Insured's Family.

Exclusion (4) in GENERAL EXCLUSIONS, pertaining to war, shall not apply to acts of terrorism.

The Payment of Claims: When Paid provision in CLAIMS PROVISIONS is deleted and replaced as follows:

Payment of Claims: When Paid: All benefits payable under the Policy other than benefits for loss of time shall be payable within sixty days after receipt of proof of loss.

The Subrogation provision in CLAIMS PROVISIONS is deleted and shall not apply.

Notice to Washington Residents:

QBTP-0001(11-10)-WA

The definitions of Covered Person(s) and Domestic Partner in GENERAL DEFINITIONS are deleted and replaced as follows:

*"**Covered Person(s)**"* means all Eligible Persons named on the Certificate who have elected to participate in this insurance program and for whom the required premium has been paid.

"Domestic Partner" means two adults who meet the requirements for a valid state registered domestic partnership as established under Washington law and who have been issued a certificate of state registered domestic partnership by the Washington Secretary of State's office.

State registered domestic partners shall be treated the same as married spouses under the Policy.

The definition of Family Member in GENERAL DEFINITIONS is amended to include the following at the end:

and spouse or Domestic Partner of any of the above.

Exclusion (11) in GENERAL EXCLUSIONS pertaining to use of drugs is deleted and shall not apply.

The following is added to the CLAIM PROVISIONS:

Disagreement Over Size of Loss. If there is a disagreement about the amount of the loss either the Insured or the Insurer can make a written demand for an appraisal. After the demand, the Insured and the Insurer each select their own competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount of the loss. If they do not agree, they will select an arbitrator. Any figure agreed to by 2 of the 3 (the appraisers and the arbitrator) will be binding. The appraiser selected by the Insured is paid by the Insured. The Insurer will pay the appraiser it chooses. The Insured will share with the Insurer the cost for the arbitrator and the appraisal process.

The following will appear at the beginning of the Subrogation provision in CLAIMS PROVISIONS:

Note: The Insured is entitled to complete reimbursement for loss before the Insurer is entitled to recovery or Subrogation proceeds. Therefore, this Subrogation provision will not apply until such complete reimbursement is received by the Insured.

The Assignment provision in GENERAL PROVISIONS is deleted and shall not apply.

The following is added to the GENERAL PROVISIONS:

Certificates of Insurance. The Insurer will electronically deliver to the Insured a Certificate of Insurance outlining the insurance coverage and to whom benefits are payable.

Notice to Wisconsin Residents:

QBTE-0001(11-10)-WI

The following is added to the MEDICAL EXPENSE BENEFIT:

(6) Skilled nursing facility expenses. Confinement therein must start within 14 days of a Hospital stay of 3 or more days. It must also be for continued treatment of the condition causing the Hospital stay. The maximum allowed charge is:
   a. For Wisconsin residents, the lesser of:
      i. The amount charged by the facility for room and board; or

      ii. The daily rate established for the facility by the Wisconsin Department of Health and Social Services;
   b. For non-Wisconsin residents, the maximum charge is one-half the Hospital's daily semi-private rate.

   The maximum period payable is 30 days per admission.

(7) Home health care services provided by a Home Health Care Agency under a Home Health Care Plan including charges for:
   a. Part-time or intermittent home nursing care by or under the supervision of a registered nurse;
   b. Part-time or intermittent home health aide services under the supervision of a registered nurse or medical social worker;
   c. The following therapy:
      i. Physical;
      ii. Respiratory;
      iii. Occupational; and
      iv. Speech;
   d. Medical supplies, drugs and medications prescribed by a Physician;
   e. Laboratory services, to the extent such items would have been covered under the Policy if You had been Hospital confined;
   f. Nutrition counseling provided by or under the supervision of a registered dietitian.

   The Home Health Care Plan must have been established in lieu of Hospital or skilled nursing facility confinement. Each visit by a member of a home health care team is considered as one home health care visit. Four hours of home health aide service is considered as one home health care visit. The maximum number of visits payable is 40 visits in any 12-month period.

"Home Health Care Agency" means:
   a. A certified rehabilitation agency;
   b. A service or agency which holds a valid certificate of approval, or license, as a public home health care agency;
   c. A Hospital holding a valid operating certificate authorizing it to provide home health care services; or
   d. An establishment approved as a home health agency under Medicare.

"Home Health Care Plan" means a program for care and treatment of a injured [or sick] Insured Person in his home by a Home Health Care Agency. The program must be established by Your attending Physician. The Physician must approve the program in writing prior to the start of home health care services. It must be reviewed by him at least every 2 months unless he feels a longer interval is sufficient. The Physician must also certify that confinement in a Hospital or skilled nursing facility would be required if home care is not provided.The Payment Of Claims: When Paid provision in CLAIM PROVISIONS is deleted and replaced with the following:

Payment Of Claims: When Paid: Benefits due shall be paid not more than 30 days after the Insurer's claim administrator's receipt of Proof of Loss. A claim shall be overdue if not paid within 30 days after they are furnished written Proof of Loss. If such written proof is not furnished to the Insurer's claims administrator as to the entire claim, any partial amount supported by written proof is overdue if not paid within 30 days after written proof is furnished to them. Any part or all of the remainder of the claim that is subsequently supported by written proof is overdue if not paid within 30 days after written proof is furnished to them. Any payment shall not be deemed overdue when the Insurer's claims administrator has reasonable proof to establish that the Insurer is not responsible for the payment, notwithstanding that written proof of loss has been furnished to them.

For the purpose of calculating the extent to which any claim is overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the U.S. mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery. All overdue payments shall bear simple interest at the rate of 12% per year.

Notwithstanding the above, a claim for payment for any covered chiropractic services is overdue if not paid within 30 days after the Insurer receives clinical documentation from the chiropractor that the services were provided unless, within those 30 days, the Insurer's claims administrator provides to the Insured and to the chiropractor the written statement under s. 632.875(2) Wis. Stat.

The following is added to the Subrogation provision in CLAIM PROVISIONS:

The Insurer's right of subrogation is limited to the amount remaining after the Insured has been made whole, taking into consideration the Insured's comparative negligence.

Notice to West Virginia Residents:

QBTE-0001(11-10)-WV

The following notice is added to the cover page:
THE POLICYHOLDER AND THE INSURED HAVE THE RIGHT TO RETURN THE POLICY OR CERTIFICATE WITHIN TEN DAYS OF ITS RECEIPT AND TO HAVE ANY PREMIUM PAID REFUNDED TO THE PAYOR IF NOT SATISFIED FOR ANY REASON AFTER EXAMINATION OF THE POLICY OR CERTIFICATE.

The following definition is added to the GENERAL DEFINITIONS:

"Medical Emergency" means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

The following is added to the MEDICAL EXPENSE BENEFIT:

(f) Charges incurred for Medically Necessary services required to treat a Medical Emergency.

The Payment of Claims: When Paid provision in CLAIMS PROVISIONS is deleted and replaced with the following:

Payment of Claims: When Paid: The Insurer's claims administrator will either pay or deny a Clean Claim within 40 days of receipt of the claim if submitted manually and within 30 days if submitted electronically. The following exceptions apply:

(a) Another payor or party is responsible for the claim;

(b) The provider has already been paid for the claim;

(c) The claim was submitted fraudulently; or

(d) There was a material misrepresentation in the claim.

Within 30 days of receiving a claim the Insurer's claims administrator will request electronically or in writing from the claimant any information or documentation they reasonably believe will be required to process and pay the claim or to determine if the claim is a Clean Claim. The Insurer's claims administrator will make every reasonable effort to ask for all information in one request. However if necessary, within 15 days of receiving the information from the Insurer's first request, they may request or require additional information one more time if such additional information could not have been reasonably identified the first time or to specifically identify a material failure to provide the information requested the first time. If after receiving the requested information they find the claim is a Clean Claim, they will either pay or deny the claim within 30 days.

Interest, at a rate of 10% per annum, accruing after the 40-day period noted above owing and accruing on any Clean Claim, will be paid and accompanied by an explanation of the assessment on each claim of interest paid, without necessity of demand, at the time the claim is paid or within 30 days thereafter.

"Clean Claim" is one: (a) that has no material defect or impropriety, including all reasonably required information and substantiating documentation, to determine eligibility or to adjudicate the claim; or (b) with respect to which the Insurer has failed to notify the person submitting the claim of any such defect or impropriety in a timely manner.

The last sentence of Proof of Loss within the Additional Claims Procedures appearing in the CLAIMS PROVISIONS is deleted.

Notice to Wyoming Residents:

QBTE-0001(11-10)-WY

The following notices are added to the face page:

THE POLICY CONTAINS LIMITED BENEFITS

THE POLICY DOES NOT INCLUDE COMPREHENSIVE ADULT WELLNESS BENEFITS

The definition of Medically Necessary in GENERAL DEFINITIONS is deleted, along with all references to this term and shall not apply. Benefits will not be subject to a determination of medical necessity.

The following is added to the Proof of Loss provision in CLAIM PROVISIONS:

Failure to furnish proof within these time frames shall not invalidate nor reduce any claim if it is shown it was not reasonably possible to furnish proof and that proof was furnished as soon as was reasonably possible.

The Payment of Claims: When Paid provision in CLAIM PROVISIONS is deleted and replaced with the following:

Payment of Claims: When Paid: Benefits other than benefits for loss of time are payable not more than 45 days after receipt of written Proof of Loss and supporting evidence. Subject to Proof of Loss and supporting evidence, all accrued benefits payable under the Policy for loss of time are payable not less frequently than monthly during the continuance of the disability period for which the Insurer is liable, and any balance remaining unpaid at the termination of the disability period is payable immediately upon receipt of proof and supporting evidence.

WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Alaska residents: "A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law."

Notice to Arizona residents: "For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

Notice to California residents: "For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

Notice to Colorado residents: "It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies."

Notice to Delaware residents: "Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of clam containing any false, incomplete or misleading information is guilty of a felony."

Notice to Florida residents: "Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree."

Notice to Idaho residents: "Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

Notice to Indiana residents: "A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony."

Notice to Kentucky residents: "Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits an fraudulent insurance act, which is a crime."

Notice to Maryland residents: "Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

Notice to Maine residents: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits."

Notice to Minnesota residents: "A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

Notice to New Hampshire residents: "Any person who, with a purpose to injure defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20."

Notice to New Jersey residents: "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

Notice to New Mexico residents: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties."

Notice to New York residents: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation."

Notice to Ohio residents: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

Notice to Oklahoma residents: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive and insurer , makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

Notice to Pennsylvania residents: "Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

Notice to Tennessee, Virginia and Washington residents: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

Notice to Texas residents: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

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