

Rental Car Damage & Emergency Evacuation Protection

Cover Page

This document holds all of the relevant information you will need in regard to your travel protection plan.

Please review the following two (2) sections:

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

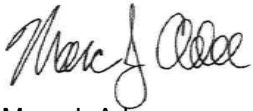
United States Fire Insurance Company
Administrative Office: 5 Christopher Way,
Eatontown, NJ 07724
(Hereinafter referred to as "the Company")

TRAVEL PROTECTION INSURANCE
Certificate of Insurance

This Certificate of Insurance describes all of the travel insurance benefits underwritten by United States Fire Insurance Company, herein referred to as the Company. The insurance benefits vary from program to program. Please refer to the accompanying Confirmation of Benefits. It provides the Insured with specific information about the program he or she purchased. The Insured should contact the Company immediately if he or she believes that the Confirmation of Benefits is incorrect.

Signed for the Company,

Chairman and CEO,



Marc J. Adee

Insurance provided by this Certificate is subject to all of the terms and conditions of the Group Policy. If there is a conflict between the Policy and Certificate, the Policy will govern.

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SECTION I. COVERAGES

EMERGENCY MEDICAL EVACUATION

When You incur a Sickness or Injury during the course of a Covered Trip, the following benefits are payable, up to the Maximum Benefit Amount.

1. If the local attending Legally Qualified Physician and the authorized travel assistance company determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment.

If You are in the Hospital for more than seven consecutive days and Your dependent children who are under 18 years of age and accompanying You on the Covered Trip, are left unattended, Economy Transportation will be paid to return the dependents to their home (with an attendant, if considered necessary by the travel assistance company).

If You are traveling alone and is in the Hospital for more than seven consecutive days and Emergency Evacuation is not imminent, upon Your or of Your next of kin if You are incapacitated, benefits will be paid to transport one person, chosen by You, by Economy Transportation, for a single visit to and from Your bedside.

2. If the local attending Legally Qualified Physician and the authorized travel assistance company determine that it is Medically Necessary for You to return to Your place of permanent residence because of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred will be paid for Your return to his or her permanent residence via:
 - i) one-way Economy Transportation; or
 - ii) commercial upgrade, based on an Insured's condition as recommended by the local attending Legally Qualified Physician and verified in writing.

Transportation must be via the most direct and economical route.

If the local attending Legally Qualified Physician and the authorized travel assistance company determine that it is Medically Necessary for You to return to his or her place of permanent residence for continued treatment of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred will be paid for transportation to the Hospital or medical facility closest to Your permanent place of residence capable of providing that treatment. Transportation must be by the most direct and economical route. Covered land or air transportation includes, but is not limited to, commercial stretcher, medical escort, or the Usual and Customary Charges for air ambulance, provided such transportation has been pre-approved and arranged by the authorized travel assistance company.

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

COLLISION DAMAGE WAIVER

The Insured is eligible for benefits up to the Maximum Benefit Amount per person if the Insured rents a car while on the Trip, and the car is damaged due to collision, theft, vandalism, windstorm, fire, hail, flood or any cause not in the Insured's control while in the Insured's possession, or the car is stolen while in the Insured's possession and is not recovered. The Company will pay the lesser of:

- (a) The cost of repairs and rental charges imposed by the rental company while the car is being repaired; or
- (b) The Actual Cash Value of the car, meaning purchase price less depreciation; or
- (c) The amount shown on the Schedule.

Coverage is provided to the Insured, provided the Insured and Traveling Companions are licensed drivers, and are listed on the rental agreement.

DEFINITIONS

"Exotic Vehicles" includes Alfa Romeo, Aston Martin, Auburn, Avanti, Bentley, Bertone, BMC/Leyland, BMW M Series, Bradley, Bricklin, Clenet, Corvette, Cosworth, De Lorean, Excalibre, Ferrari, Iso, Jaguar, Jensen Healy, Lamborghini, Lancia, Lotus, Maserati, Mercedes Benz, MG, Morgan, Pantera, Panther, Pininfarina, Porsche, Rolls Royce, Rover, Stutz, Sterling, Triumph, and TVR.

WHAT IS NOT PAYABLE UNDER COLLISION DAMAGE WAIVER:

Unless otherwise stated, benefits are not payable for:

1. Any obligation of the Insured, a Traveling Companion or Family Member traveling with the Insured assumed under any agreement (except insurance collision deductible);
2. Rentals of trucks, campers, trailers, off-road or four wheel drive vehicles, motor bikes, motorcycles, recreational vehicles or Exotic Vehicles;
3. Any loss which occurs if the Insured or anyone traveling with the Insured are in violation of the rental agreement;
4. Failure to report the loss to the proper local authorities and the rental car company;
5. Damage to any other vehicle, structure or person as a result of a covered loss;
6. Any loss as the result of or attributed to driving the rental vehicle: while under the influence of alcohol or any illegal substance or the abuse of a legal substance; while using any medication which recommends abstinence from driving; in a speed competition; for compensation for hire; for illegal trade purposes, or transporting contraband;
7. Any loss as the result of physical damage or loss attributed to: mechanical failure or breakdown of the rental vehicle; wear and tear, gradual deterioration, corrosion, rust or freezing; any neglect or abuse of the vehicle; any dishonest act or conversion; any consequence of war (declared or otherwise); or contamination by a radioactive material.

ADDITIONAL CLAIMS PROVISIONS SPECIFIC TO COLLISION DAMAGE WAIVER:

The following outlines the Insured's Duties in the event of any damage to the vehicle. The Insured must:

- a) Take all necessary and reasonable steps to protect the vehicle and prevent further damage to it;
- b) Report the loss to the appropriate local authorities and the rental company as soon as possible;
- c) Obtain all information on any other party involved in the Accident, such as name, address, insurance information and driver's license number;
- d) Provide the Company all documentation such as rental agreement, police report and damage estimate.

SECTION II. DEFINITIONS

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

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

"Confirmation of Benefits" means the coverage confirmation provided to You following enrollment and payment of the applicable premium.

"Covered Trip" means scheduled trips, tours or cruises for which (a) coverage is requested: and (b) the required premium is submitted prior to the Scheduled Departure Date.

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

"Family Member" means Your or a Traveling Companion's: legal spouse or common-law spouse where legal; legal guardian; son or daughter (adopted, foster or step); son-in-law; daughter-in-law; grandmother; grandmother-in-law; grandfather; grandfather-in-law; grandchild; aunt; uncle; niece; or nephew; brother, step-brother; sister; step-sister; brother-in-law; sister-in-law; mother; father; step-parent.

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

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

"Insured" means the person(s) named on the enrollment form or Roster as the Principal Participant, participant's spouse or participant's child.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION III. INSURING PROVISIONS

Insured’s Term of Coverage:

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

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

SECTION IV. GENERAL LIMITATIONS AND EXCLUSIONS

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

1. resulting from suicide, attempted suicide or any intentionally self-inflicted injury while sane or insane;
2. resulting from an act of declared or undeclared war;
3. while participating in maneuvers or training exercises of an armed service;
4. while riding, driving or participating in races, or speed or endurance contests;
5. while mountaineering (engaging in the sport of scaling mountains generally requiring the use of picks, ropes, or other special equipment);
6. while participating as a member of a team in an organized sporting competition;
7. while participating in skydiving, hang gliding, bungee cord jumping, scuba diving or deep sea diving;
8. while piloting or learning to pilot or acting as a member of the crew of any aircraft;
9. received as a result or consequence of being Intoxicated, as specifically defined in the policy, or under the influence of any controlled substance unless administered on the advise of a Legally Qualified Physician;
10. to which a contributory cause was the commission of or attempt to commit a felony or being engaged in an illegal occupation;
11. due to normal childbirth, normal pregnancy through the first 6 months of pregnancy or voluntarily induced abortion;
12. which exceed the Maximum Benefit Amount for each attached coverage as shown in the Confirmation of Benefits.

SECTION V. GENERAL PROVISIONS

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

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

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

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

Payment of Claims: Benefits for loss of life are payable to the Principal Insured, who is the beneficiary for all other Insureds. If: (a) the Principal Insured predeceases You; and (b) a beneficiary is not otherwise designated by the Principal Insured benefits for loss of life will be paid to the first of the following surviving preference beneficiaries:

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

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

Other than for loss of life, if any benefit is payable to: (a) You or the Principal Insured's beneficiary who is minor or otherwise not able to give a valid release; or (b) the Principal Insured's estate: the Company may pay up to \$1,000.00 to the Principal Insured's beneficiary or any relative to whom the Company finds entitled to the payment. Any payment made in good faith shall fully discharge the Company to the extent of such payment.

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

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

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

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

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

STATE EXCEPTIONS

NEW HAMPSHIRE: The definition of "Family Member" is amended to read:

"Family Member" means an Insured's or a Traveling Companion's: legal spouse or common-law spouse where legal; legal guardian; son or daughter (adopted, foster or step); child placed for adoption with the Insured or Traveling Companion; son-in-law; daughter-in-law; grandmother; grandmother-in-law; grandfather; grandfather-in-law; grandchild; aunt; uncle; niece; or nephew; brother, step-brother; sister; step-sister; brother-in-law; sister-in-law; mother; father; step-parent.

The definition of "Hospital" is amended to read:

"Hospital" means (a) a place that operates according to law in the state where it is located; and b) a place operated for the care and treatment of resident inpatients with a registered graduate nurse (RN) always on duty and with a laboratory and X-ray facility: Not included is a hospital or institution licensed or used principally: (1) for the treatment or care of drug addicts or alcoholics: or (2) as a clinic continued or extended care facility, skilled nursing facility, convalescent home, rest home, nursing home or home for the aged.

"Proof of Loss" is amended to read:

Proof of Loss: Proof of loss must be provided within 90 days after the date of the loss or as soon as is reasonably possible.

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

United States Fire Insurance Company

PRIVACY POLICY AND PRACTICES

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

Your Privacy is Our Concern

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

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

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

What do we do with the information collected about you?

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

To whom do we disclose information about you?

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

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

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

How to contact Us

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

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

When used throughout this document “Company”, “Our”, “We”, or “Us” means:

United States Fire Insurance Company

GRIEVANCE PROCEDURES

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

DEFINITIONS

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

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

INFORMAL GRIEVANCE PROCEDURE

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

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

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

FORMAL GRIEVANCE PROCEDURE

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

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

First Level Review

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

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

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

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

- (6) A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review

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

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

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

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

The panel must be comprised of persons who:

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

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

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

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

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

EXPEDITED REVIEW

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

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24-hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a

decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72-hours after the review has commenced. Written confirmation of our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements for First Level reviews.

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.

GRIEVANCE PROCEDURES **(Applicable to Residents of NEW HAMPSHIRE Only)**

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

DEFINITIONS

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

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

INFORMAL GRIEVANCE PROCEDURE

If you have a complaint about a claim denial, you, your authorized representative, or a provider acting on your behalf may call our Customer Services department at 1-(888) 253-1418 to informally resolve your complaint. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to further explain the issue or immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within 5-business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 15-days after receiving the complaint and all necessary information.

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

FORMAL GRIEVANCE PROCEDURE

In the event of an Adverse Determination, you, your authorized representative, or a provider acting on your behalf may submit a formal Grievance within 180-days following receipt of the Adverse Determination.

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

In the event you fail to submit all information needed to decide the appeal. We will notify you in writing of precisely what is required. You will have 45-days within which to respond to our request and provide sufficient information. If you fail to provide the necessary information within that timeframe, we may deny the appeal on the basis of incompleteness.

Internal First Level Review

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

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

Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 30-days after receiving the Grievance. The written decision must include:

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

External Second Level Review

The External Second Level Review process is available if you are not satisfied with the outcome of the Internal First Level Review for an Adverse Determination or if you have requested an Informal or Internal First Level Review and did not receive a decision from the Company within the time frames allowed for such reviews. Within 10-business days after receiving a request for an External Second Level Review, we or our designated utilization review organization will provide you and the selected independent review organization with the following:

- (1) The name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;
- (2) A statement of your rights, including the right to:
 - Attend the External Second Level Review;
 - Present his/her case to the review panel;
 - Submit supporting materials before and at the review meeting;
 - Ask questions of any member of the review panel;
 - Be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney;
 - Request and receive from us free of charge, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination;
- (3) A copy of your health insurance contract, evidence of coverage, benefit summary, or similar document;
- (4) All relevant medical records;
- (5) A summary of the applicable issues, including a statement of our final determination;
- (6) The clinical review criteria used and the clinical reasons for the determination;
- (7) Any communications between you and us regarding the Informal or Internal First Level Review; and
- (8) All other documents, information, or criteria relied upon by us in making our determination.

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

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

The panel must be comprised of persons who:

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

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

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

A written statement of the External Second Level Review panel's decision will be issued to you and, if applicable, to your representative or provider, within 10-business days after completing the review meeting. The decision will include:

- (1) The name(s), title(s) and qualifying credentials of the members of the review panel;
- (2) A statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;

- (3) The review panel's recommendation to the Company and the rationale behind the recommendation;
- (4) A description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation;
- (5) In the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination;
- (6) The rationale for the Company's decision if it differs from the review panel's recommendation;
- (7) A statement that the decision is the Company's final determination in the matter;
- (8) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED REVIEW

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

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

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective review of Adverse Determinations.

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to read your policy carefully, or contact your local U.S. Department of Labor Office, or the New Hampshire Department of Insurance.

The New Hampshire Insurance Department is available to assist you with insurance related problems and questions.

You may inquire:

**By writing to: NH Insurance Department
21 South Fruit Street
Concord, NH 03301-7317**

By telephone: 603-271-2261, direct or toll-free at 1-800-852-3416

NON-INSURANCE WORLDWIDE ASSISTANCE SERVICES

On Call International

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

- **CareFree™ Travel Assistance**
- **Medical Assistance**
- **Emergency Services**

CareFree™ Travel Assistance

Travel Arrangements

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

Pre-Trip Information

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

Documents and Communication

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

Medical Assistance Services

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

Emergency Services

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

CareFree™ Travel Assistance, Medical Assistance™ and Emergency Services can be accessed by calling On Call International at **1-855-892-6490** or, from outside the U.S. or Canada, call collect: **1-603-328-1378**.

CLAIMS PROCEDURE

1. EMERGENCIES ARISING DURING YOUR COVERED TRIP: Please contact On Call International (as above).

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

Online: www.aontravelclaim.com

Phone: 1-(888) 253-1418 or 1-(516) 342-7300

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