NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 15th Floor, New York, NY 10038
(212) 458-5000
(a capital stock company, herein referred to as the Company)

Policyholder: Southeastern Louisiana University
Policy Number: SRG 0009157733

BLANKET ACCIDENT INSURANCE
Description of Coverage

Effective Date: August 16, 2020

This Description of Coverage describes blanket accident insurance coverage provided to eligible persons of the policyholder named above (herein called the Policyholder) while those persons are participating in Covered Activities.

Who Is Eligible
The persons eligible for coverage under the above referenced blanket accident insurance policy (herein called the Policy) issued to the Policyholder are: All registered Full Time international students and scholars of the Policyholder, under the age of 65, with a current passport and a F-1 or J-1 visa, whose name is on file and for whom premium has been paid and:

- Who are temporarily residing outside their home country as a nonresident alien;
- Is engaged in educational activities of the Member; and
- Has not obtained permanent residency status in the United States; and
- Is not a U.S. Citizen

What Activities Are Covered
Covered Activity/ies are: 24 hours while in the U.S. and participating in education or educational activities or research related activities of the Policyholder. Coverage expires the earlier of the day the education trip ends or the expiration of the policy. Enrollment in coverage cannot exceed 52 weeks.

Coverage excludes: distance learning courses; students solely taking off-campus internet, home study, correspondence or television courses; courses taken for audit and intercollegiate sports.

PLEASE READ THIS DESCRIPTION OF COVERAGE CAREFULLY

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Maximum Amount: $10,000

Accidental Dismemberment Benefit
Maximum Amount: $10,000

Accident Medical Expense Benefit
Overall Accident Medical Expense Maximum Amount: $250,000

Deductible: $25 per accident

Maximum Amount for Physical Therapy: $50 per Day
Maximum Number of Days: 20
Note: Expenses charged to the maximum for the above services are also subject to the Overall Accident Medical Expense Maximum Amount shown above.

Maximum Amount for Occupational Therapy: $50 per Day
Maximum Number of Days: 20
Note: Expenses charged to the maximum for the above services are also subject to the Overall Accident Medical Expense Maximum Amount shown above.

Maximum Amount for Prescription Drugs: $1,000
Note: Expenses charged to the maximum for the above prescriptions drugs are also subject to the Overall Accident Medical Expense Maximum Amount shown above.

Maximum Amount for Emergency Room/Ambulatory Medical Center: $50,000
Note: Expenses charged to the maximum for the above Emergency Room/Ambulatory Medical Center are also subject to the Overall Accident Medical Expense Maximum Amount shown above.

Maximum Amount for Ambulance: $500
Note: Expenses charged to the maximum for the above ambulance are also subject to the Overall Accident Medical Expense Maximum Amount shown above.

Dental Maximum: $500 per accident
Note: Expenses charged to the maximum for the above Dental services are also subject to the Overall Accident Medical Expense Maximum Amount shown above.

Dental Maximum Amount per tooth: $100 per accident
Note: Expenses charged to the maximum for the above Dental services per tooth are also subject to the Dental Maximum Amount shown above.

Bereavement and Trauma Counseling Benefit
Maximum Amount per Session: $250 per accident
Maximum Number of Sessions: 20 per accident

Emergency Evacuation with Family Travel Benefit
Maximum Amount: $250,000

Felonious Assault Benefit (Dollar Amount)
Maximum Amount: $5,000

Psychological Therapy Benefit

Maximum Amount Per Session:	$50 per accident
Maximum Number of Sessions:	10 per accident

Repatriation of Remains Benefit

Maximum Amount:	$50,000

Sickness Medical Expense Benefit

Overall Sickness Medical Expense Maximum Amount:	$250,000

Maximum Amount for Physical Therapy:	$50 per Day
Maximum Number of Days:	20

Note: Expenses charged to the maximum for the above services are also subject to the Overall Sickness Medical Expense Maximum Amount shown above.

Maximum Amount for Occupational Therapy:	$50 per Day
Maximum Number of Days:	20

Note: Expenses charged to the maximum for the above services are also subject to the Overall Sickness Medical Expense Maximum Amount shown above.

Maximum Amount for Prescription Drugs: $1,000

Note: Expenses charged to the maximum for the above prescriptions drugs are also subject to the Overall Sickness Medical Expense Maximum Amount shown above.

Maximum Amount for Emergency Room /Ambulatory Medical Center: $50,000

Note: Expenses charged to the maximum for the above Emergency Room/Ambulatory Medical Center are also subject to the Overall Sickness Medical Expense Maximum Amount shown above.

Maximum Amount for Ambulance: $500

Note: Expenses charged to the maximum for the above ambulance are also subject to the Overall Sickness Medical Expense Maximum Amount shown above.

Dental Maximum: $500 per Sickness

Note: Expenses charged to the maximum for the above Dental services are also subject to the Overall Sickness Medical Expense Maximum Amount shown above.

Dental Maximum Amount per tooth: $100 per Sickness

Note: Expenses charged to the maximum for the above Dental services per tooth are also subject to the Dental Maximum Amount shown above.

The Maximum Amounts are used to determine amounts payable under each Benefit. Actual amounts payable will not exceed the maximums, and may be less than the maximums under circumstances specified in the Policy.

Aggregate Limit: $250,000

Definitions

Hospital – means a facility that: (1) is operated according to law for the care and treatment of 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 (RNs) and (4) is supervised by one or more Physicians. 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 rest home, nursing home, convalescent home 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; or (3) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except if there is a legal obligation to pay.

Injury - means bodily injury: (1) which is sustained as a direct result of an unintended, unanticipated accident that is external to the body and that occurs while the injured person's coverage under the Policy is in force; (2) which occurs while such person is participating in a Covered Activity; and (3) which directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a covered loss.

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

Maximum Amount. As applicable to each Benefit provided by the Policy for You, Maximum Amount means the amount shown as the maximum amount for that Benefit for Your eligible class in the Benefit Schedule, subject to the Reduction Schedule shown below.

Physician - means a licensed practitioner of the healing arts acting within the scope of his or her license who is not: 1) You; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Pre-existing Condition – means a condition for which You receive any diagnosis, medical advice or treatment or had taken any prescription medicines during the 6 months immediately preceding the effective date of Your coverage under the Policy unless the condition for which the prescribed medication is taken remains controlled without any change in the required prescription.

You, Your – means a person: (1) who is a member of an eligible class of persons as described in the Who is Eligible section of this Description of Coverage; (2) for whom premium has been paid; and (3) while covered under the Policy.

Your Effective and Termination Dates

Effective Date. Your coverage under the Policy begins on the latest of: (1) the Policy Effective Date; (2) the date for which the first premium for Your coverage is paid; or (3) the date You become a member of Southeastern Louisiana University.

A change in Your coverage under the Policy due to a change in Your eligible class or Covered Activity becomes effective on the later of (1) when the change in Your eligible class or Covered Activity occurs; or (2) if the change requires a change in premium, the date the first changed premium is paid. However, a change in coverage applies only with respect to accidents that occur once the change is effective.

Termination Date. Your coverage under the Policy ends on the earliest of: (1) the date the Policy is terminated; (2) the premium due date if premiums are not paid when due; or (3) the date You cease to be a member of Southeastern Louisiana University.

Termination of coverage will not affect a claim for a covered loss that occurred while Your coverage was in force under the Policy.

Description of Benefits

The Maximum Amounts shown in the Benefit Schedule, subject to the Reduction Schedule, are used to determine amounts payable under each Benefit.

Reduction Schedule. The Maximum Amount used to determine the amount payable for a loss will be reduced if You are age 70 or older on the date of the accident causing the loss with respect to any of the following Benefits provided by the Policy: Accidental Death Benefit, Accidental Dismemberment Benefit, Felonious Assault Benefit. The Maximum Amount is reduced to a percentage of the Maximum Amount that would be used if You were under age 70 on the date of the accident, according to the following schedule:

AGE ON DATE OF ACCIDENT	PERCENTAGE OF UNDER-AGE-70 MAXIMUM AMOUNT
70-74	65%
75-79	45%
80-84	30%
85 and older	15%

Your premium, if You are age 70 or older, is based on 100 % of the coverage that would be in effect if You were under age 70.

"Age" as used above refers to Your age on Your most recent birthday, regardless of the actual time of birth.

Accidental Death Benefit. If You suffer an Injury that results in death within 365 days of the date of the accident that caused the Injury, the Company will pay You 100% of the Maximum Amount.

Accidental Dismemberment Benefit. If You suffer an Injury that results, within 365 days of the date of the accident that caused the Injury, in any one of the Losses specified below, the Company will pay the percentage of the Maximum Amount shown below for that Loss:

For Loss of:	Percentage of Maximum Amount
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Hand or One Foot	50%
The Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Hearing in One Ear	25%
Thumb and Index Finger of Same Hand	25%

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means total and irrecoverable loss of the entire sight in that eye. "Loss" of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. "Loss" of speech means total and irrecoverable loss of the entire ability to speak. "Loss of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits. "Loss" of finger means complete severance through or above the metacarpophalangeal joint of the digit.

If You sustain more than one Loss as a result of the same accident, only one amount, the largest, will be paid.

Exposure and Disappearance. If by reason of an accident occurring while Your coverage is in force under the Policy, You are unavoidably exposed to the elements and as a result of such exposure suffer a loss for which a benefit is otherwise payable under the Policy, the loss will be covered under the terms of the Policy.

If Your body has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which You were an occupant while covered under the Policy, then it will be deemed, subject to all other terms and provisions of the Policy, that You have suffered accidental death within the meaning of the Policy.

Accident Medical Expense Benefit. If You suffer an Injury that, within 90 days of the date of the accident that caused the Injury, requires You to be treated by a Physician, the Company will pay the Usual and Customary Charges incurred for Medically Necessary Covered Accident Medical Services received due to that Injury, up to the Maximum Amount for all Injuries caused by the same accident. The benefit is payable only for such charges incurred after the Deductible has been met. Benefits are then payable for charges incurred within 52 weeks after the date of the accident causing the Injury.

No expenses paid under this Benefit will be payable under any other Benefit under the Policy.

Covered Accident Medical Service(s) - means any of the following services:

1. services of a Physician;
2. private duty nursing by a registered nurse (R.N.) or Licensed Practical Nurse (LPN);
3. laboratory tests;
4. radiological procedures;
5. anesthetics and the administration of anesthetics;
6. blood, blood products and artificial blood products, and the transfusion thereof;
7. physical therapy except that an office visit connected with any such service is payable up to the per Day Maximum in the Benefit Schedule;
8. occupational therapy except that an office visit connected with any such service is payable up to the per Day Maximum in the Benefit Schedule;
9. rental of Durable Medical Equipment;
10. artificial limbs, artificial eyes or other prosthetic appliances;
11. medicines or drugs administered by a Physician or that can be obtained only with a Physician's written prescription up to the Prescription Drug Maximum in the Benefit Schedule;
12. Hospital emergency room or Ambulatory Medical Center up to the Emergency Room/Ambulatory Medical Center Maximum in the Benefit Schedule;
13. Hospital's most common charge for semi-private room and board (or room and board in an intensive care unit); Hospital ancillary services (including, but not limited to, use of the operating room);
14. ambulance service to or from a Hospital up to the Ambulance Maximum in the Benefit Schedule.

EXCLUSIONS. In addition to the standard exclusions under the Policy and any amendment thereto, Accident Medical Expense benefits are not payable for, and Usual and Customary Charges for Covered Accident Medical Services do not include, any expense for or resulting from any of the following:

1. repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or rental of existing Durable Medical Equipment unless for the purpose of modifying the item because Injury has caused further impairment in the underlying bodily condition;

2. new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except for repair or replacement of sound natural teeth damaged or lost as a result of Injury up to the Dental Maximum shown in the Benefit Schedule;

3. new eye glasses or contact lenses or eye examinations related to the correction of vision or related to the fitting of glasses or contact lenses, unless Injury has caused impairment of sight; or repair or replacement of existing eyeglasses or contact lenses unless for the purpose of modifying the item because Injury has caused further impairment of sight;

4. new hearing aids or hearing examinations unless Injury has caused impairment of hearing; or repair or replacement of existing hearing aids unless for the purpose of modifying the item because Injury has caused further impairment of hearing;

5. rental of Durable Medical Equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (but if, in the Company's sole judgment, Accident Medical Expense benefits for rental of Durable Medical Equipment are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the Company may, but is not required to, choose to consider such purchase expense as a Usual and Customary Charges Covered Accident Medical Expense in lieu of such rental expense);

6. any charge for medical care for which You are not legally obligated to pay;

7. care, treatment or services provided by You or by an Immediate Family Member;

8. routine physical exam and related medical services;

9. personal comfort or convenience items, such as but not limited to, Hospital telephone charges, television rental, or guest meals while confined in a Hospital or for items taken away or home from the Hospital, except Durable Medical Equipment;

10. Pre-existing Conditions;

11. an Emergency Evacuation for which any benefits are payable under the Policy's Emergency Evacuation Benefit;

12. elective treatment or surgery;

13. Experimental or Investigative treatment or procedures;

14. treatment for temporomandibular dysfunction;

15. care, treatment or services provided by persons retained or employed by the Policyholder; or for supplies, prescriptions or medicines paid for or reimbursable by the Policyholder, or for which a charge is not made;

16. Mental Illness, psychological or psychiatric counseling of any kind, mental and nervous disease or disorders and rest cures;

17. educational or vocational testing or training;

18. treatment of Osgood-Schlatter's disease;

19. detached retina unless due to an Injury;

20. plastic or cosmetic surgery;

21. charges that are payable under motor vehicle medical benefits;

22. hernia.

Definitions. The following are additional definitions that apply to the Accident Medical Expense Benefit.

Ambulatory Medical Center - means a licensed facility providing ambulatory surgical or medical treatment, other than a Hospital, clinic or Physician's office.

Deductible - means the amount of Usual and Customary Charges for Medically Necessary Covered Accident Medical Services that must be incurred by You before Accident Medical Expense benefits become payable. The amount of the Deductible is the Deductible Amount shown in the Benefit Schedule. Accident Medical Expense benefits are not payable for charges applied to the Deductible.

Durable Medical Equipment - refers to equipment of a type that is designed primarily for use, and used primarily, by people who are injured (for example, a wheelchair or a hospital bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of injury or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

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, including 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 government agency approval not received at the time the services are rendered.

Medically Necessary – means a Covered Accident Medical Service that: (1) is essential for diagnosis, treatment or care of the Injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician and performed under his or her care, supervision or order.

Mental Illness – means any disturbance of emotional equilibrium, as manifested in maladaptive behavior and impaired functioning, caused by genetic, physical, chemical, biologic, psychological, or social and cultural factors. Also called emotional illness, mental/nervous disorder and psychiatric disorder.

Usual and Customary Charge(s) - means a charge that: (1) is made for a Covered Accident Medical Service; (2) does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

Bereavement and Trauma Counseling Benefit. If You suffer an accidental death or an accidental dismemberment for which an Accidental Death or Accidental Dismemberment benefit is payable under the Policy, the Company will pay Covered Bereavement and Trauma Counseling Expenses that are due to Your death or dismemberment. The Covered Bereavement and Trauma Counseling Expenses must be incurred within one year after the date of the accident causing such loss(es), and the benefit will be paid up to the Maximum Amount shown in the Benefit Schedule per Session, subject to the Maximum Number of Sessions shown in the Benefit Schedule, for You and all of Your Immediate Family Members combined with respect to all such losses caused by the same accident.

Definitions. The following are additional definitions that apply to the Bereavement and Trauma Counseling Benefit.

Covered Bereavement and Trauma Counseling Expense(s) - means an expense that: (1) is charged for a Medically Necessary Bereavement or Trauma Counseling Session for You and/or one or more of Your Immediate Family Member(s) provided under the care, supervision or order of a Physician; (2) does not exceed the usual level of charges for similar counseling sessions in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

Medically Necessary Bereavement or Trauma Counseling Session (Session)- means any individual, joint or family mental health counseling session that: (1) is essential to assist You and/or one or more Immediate Family Members in coping with the loss for which it is provided; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician.

EXCLUSIONS. In addition to the standard exclusions under the Policy and any amendment thereto, Bereavement and Trauma Counseling Expenses do not include, any expense for or resulting from any of the following: 1) any Workers' Compensation Act or similar law; or 2) the Accident Medical Expense Benefit.

Emergency Evacuation with Family Travel Benefit. The Company will pay for Covered Emergency Evacuation Expenses reasonably incurred if You suffer an Injury or Emergency Sickness that warrants Your Emergency Evacuation while You are outside a 100 mile radius from Your place of primary residence, but not exceeding the Maximum Amount for all Emergency Evacuations due to all Injuries from the same accident or all Emergency Sicknesses from the same or related causes.

The Emergency Evacuation must be ordered by a Physician who certifies that the severity of Your Injury or Emergency Sickness warrants Your Emergency Evacuation. All Transportation arrangements made for the Emergency Evacuation must be by the most direct and economical conveyance and route possible.

Travel Guard Group, Inc. must make all arrangements and must authorize all expenses in advance for any Emergency Evacuation benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact Travel Guard Group, Inc. in advance.

Family Travel Benefit. Following a covered Emergency Evacuation for which an Emergency Evacuation benefit is payable under the Policy, the Company will pay for expenses reasonably incurred:

> to bring one person chosen by You to and from the hospital or other medical facility where You are confined if You are alone and if the place of confinement is outside a 100 mile radius from Your place of primary residence; but not to exceed the cost of one round-trip economy airfare ticket.

Travel Guard Group, Inc. must make all arrangements and must authorize all expenses in advance for any Family Travel benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact Travel Guard Group, Inc. in advance.

EXCLUSIONS: The Sickness exclusions in the Exclusions section of the Policy or as amended shall not apply with respect to benefits payable under the Emergency Evacuation Benefit with Family Travel Benefit.

Definitions. The following are additional definitions that apply to the Emergency Evacuation and Family Travel Benefit, as applicable.

Covered Emergency Evacuation Expense(s) – means an expense that: (1) is charged for a Medically Necessary Emergency Evacuation Service; (2) does not exceed the usual level of charges for similar Transportation, treatment, services or supplies in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

Emergency Evacuation – means if warranted by the severity of Your Injury or Emergency Sickness: (1) Your immediate Transportation from the place where You suffer an Injury or Emergency Sickness to the nearest

hospital or other medical facility where appropriate medical treatment can be obtained; (2) Your Transportation to Your place of primary residence to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Emergency Sickness and being treated at a local hospital or other medical facility; or (3) both (1) and (2) above. An Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.

Emergency Sickness – means an illness or disease, diagnosed by a Physician, which meets all of the following criteria: (1) there is present a severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of Your condition or place Your life in jeopardy; (2) the severe or acute symptom occurs suddenly an unexpectedly; and (3) the severe or acute symptom occurs while the Policy is in force as to You suffering the symptom and while You are participating in a Covered Activity.

Medically Necessary Emergency Evacuation Service – means any Transportation, medical treatment, medical service or medical supply that: (1) is an essential part of an Emergency Evacuation due to the Injury or Emergency Sickness for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) either is ordered by a Physician and performed under his or her care or supervision or order, or is required by the standard regulations of the conveyance transporting You.

Transportation – means moving You during an Emergency Evacuation by a land, water or air conveyance. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.

Felonious Assault Benefit (Dollar Amount). The Company will pay 100% of the Maximum Amount when You suffer one or more losses for which benefits are payable under the Accidental Death Benefit, Accidental Dismemberment Benefit provided by the Policy as a result of a Felonious Assault:

1. that is not a moving violation as defined under the applicable state motor vehicle laws; and
2. that is not an act of an Immediate Family Member, another Insured or an individual who resides with You on a permanent basis.

Only one benefit is payable for all losses as a result of the same Felonious Assault.

Felonious Assault – as used in Felonious Assault Benefit, means any willful or unlawful use of force upon You: (1) with the intent to cause bodily Injury to You; and (2) that results in bodily harm to You; and (3) that is a felony or a misdemeanor in the jurisdiction in which it occurs.

Psychological Therapy Benefit. If Your Injury results in an accidental dismemberment for which an Accidental Dismemberment benefit is payable under the Policy, the Company will pay Covered Psychological Therapy Expenses that are incurred as a direct result of the Injury causing the accidental dismemberment. The Covered Psychological Therapy Expenses must be incurred within one year after the date of the accident causing the Injury which resulted in the accidental dismemberment. The benefit will be paid up to the Maximum Amount per Session shown in the Benefit Schedule, subject to the Maximum Number of Sessions shown in the Benefit Schedule for You with respect to the accidental dismemberment. If a covered expense payable under this Benefit is also payable under one or more other Benefits under the Policy, the covered expense will be paid under only one Benefit, the one with the largest benefit amount.

Definitions. The following are additional definitions that apply to the Psychological Therapy Benefit.

Covered Psychological Therapy Expense(s) means an expense that: (1) is charged for a Medically Necessary Psychological Therapy Session for You provided under the care or supervision of a Physician; (2) does not exceed the usual level of charges for similar therapy sessions in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

Medically Necessary Psychological Therapy Session means any individual, joint or family mental health counseling session that: (1) is essential to assist You in coping with the accidental dismemberment; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician.

EXCLUSIONS. In addition to the Exclusions in the General Exclusions section of the Policy, Covered Psychological Therapy Expenses do not include any expenses for or resulting from an Injury for which You are entitled to benefits paid or payable by any Workers' Compensation Act or similar law.

Repatriation of Remains Benefit. If You suffer loss of life due to Injury or Emergency Sickness while outside a 100 mile radius from Your current place of primary residence, the Company will pay, subject to the limitations set out herein, for covered expenses reasonably incurred to return Your body to Your current place of primary residence, but not exceeding the Maximum Amount.

Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

Travel Guard Group, Inc. must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Guard Group, Inc. in advance.

EXCLUSIONS: The Exclusion for sickness, disease or infections of any kind does not apply with respect to the Repatriation of Remains Benefit.

Emergency Sickness – as used in the Repatriation of Remains Benefit, means an illness or disease, diagnosed by a Physician, which meets all of the following criteria: (1) there is a present severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of Your condition or place Your life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs while Your coverage under the Policy is in force and while You are participating in a Covered Activity.

Sickness Medical Expense Benefit. If You suffer a Sickness which requires treatment by a Physician within 7 days of the onset of the Sickness , the Company will pay the Usual and Customary Charges incurred for Medically Necessary Covered Sickness Medical Services received due to that Sickness up to the Maximum Amount. This benefit is payable only for such charges incurred within 52 weeks from the date of the onset of the Sickness.

No expenses paid under this Benefit will be payable under any other Benefit in the Policy.

Covered Sickness Medical Service(s) - means charges incurred for any of the following services:

1. services of a Physician;
2. private duty nursing by Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);
3. laboratory tests;
4. radiological procedures;
5. anesthetics and the administration of anesthetics;
6. blood, blood products and artificial blood products, and the transfusion thereof;
7. physical therapy except that an office visit connected with any such service is payable up to the per Day Maximum in the Benefit Schedule;
8. occupational therapy except that an office visit connected with any such service is payable up to the per Day Maximum in the Benefit Schedule;
9. rental of Durable Medical Equipment;
10. artificial limbs, artificial eyes or other prosthetic appliances;

11. medicines or drugs administered by a Physician or that can be obtained only with a Physician's written prescription up to the Prescription Drug Maximum in the Benefit Schedule;
12. Hospital emergency room or Ambulatory Care Center up to the Emergency Room/Ambulatory Medical Center Maximum in the Benefit Schedule;
13. Hospital's most common charge for semi-private room and board (or room and board in an intensive care unit); Hospital ancillary services (including, but not limited to, use of the operating room);
14. ambulance service to or from a Hospital up to the Ambulance Maximum shown on the Benefit Schedule.

EXCLUSIONS. In addition to the standard exclusions under the Policy and any amendment thereto, Sickness Medical Expense benefits are not payable for, and Usual and Customary charges for treatment of Sickness do not include, any expense resulting from any of the following:

1. repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or rental of existing Durable Medical Equipment, unless for the purpose of modifying the item because a Sickness has caused further impairment in the underlying bodily condition;

2. new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except for repair or replacement of sound natural teeth damaged or lost as a result of a Sickness up to the Dental Maximum shown in the Benefit Schedule;

3. new eyeglasses or contact lenses, or eye examinations related to the correction of vision or related to the fitting of glasses or contact lenses unless for the purpose of modifying the item because a Sickness has caused further impairment of sight; or repair or replacement of existing eyeglasses or contact lenses unless for the purpose of modifying the item because a Sickness has caused further impairment of sight;

4. new hearing aids or hearing examinations unless a Sickness has caused impairment of hearing; or repair or replacement of existing hearing aids unless for the purpose of modifying the item because a Sickness has caused impairment of hearing;

5. rental of Durable Medical Equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (if, in the Company's sole judgment, Sickness Medical Expense benefits for rental of Durable Medical Equipment are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the Company may, but is not required to, choose to consider such purchase expense as a Usual and Customary Covered Sickness Medical Expense in lieu of such rental expense);

6. Injury of any kind;

7. any charge for medical care for which You are not legally obligated to pay;

8. care, treatment or services provided by You or by an Immediate Family Member;

9. routine physical examination and related medical services;

10. personal comfort or convenience items such as, but not limited to Hospital telephone charges, television rental or guest meals while confined in a Hospital or for items taken away or home from the Hospital, except Durable Medical Equipment;

11. Pre-existing Conditions;

12. an Emergency Evacuation for which any benefits are payable under the Policy's Emergency Evacuation Benefit;

13. elective treatment or surgery;

14. Experimental or Investigative treatment or procedures;

15. treatment for temporomandibular joint dysfunction;

16. care, treatment or services provided by persons retained or employed by the Policyholder; or for supplies, prescriptions or medicines paid for or reimbursable by the Policyholder, or for which a charge is not made;

17. Mental Illness, psychological or psychiatric counseling of any kind, mental and nervous disease or disorders and rest cures;

18. Educational or vocational testing or training;

19. treatment of Osgood-Schlatter's disease;

20. detached retina;

21. plastic or cosmetic surgery;

22. Alcohol and Substance Abuse;

23. venereal disease or syphilis;

24. hernia.

The Sickness exclusions in the Exclusions section of the Policy or as amended shall not apply with respect to benefits payable under the Sickness Medical Expense Benefit.

Definitions. The following are additional definitions that apply to the Sickness Medical Expense Benefit.

Alcohol and Substance Abuse – means the overindulgence in or dependence on a stimulant, depressant or other chemical substance, leading to effects that are detrimental to the individual's physical or mental health or the welfare of others.

Ambulatory Medical Center – means a licensed facility providing ambulatory surgical or medical treatment, other than a Hospital, clinic or Physician's office.

Durable Medical Equipment - refers to equipment of a type that is designed primarily for use, and used primarily, by people who are sick (for example, a wheelchair or a hospital bed). It does not include items commonly used by people who are not sick, even if the items can be used in the treatment of a Sickness or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

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, including 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 government agency approval not received at the time the services are rendered.

Medically Necessary –means a Covered Sickness Medical Service that: (1) is essential for diagnosis, treatment or care of the Sickness for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician and performed under his or her care, supervision or order.

Mental Illness – means any disturbance of emotional equilibrium, as manifested in maladaptive behavior and impaired functioning, caused by genetic, physical, chemical, biologic, psychological, or social and cultural factors. Also called emotional illness, mental/nervous disorder and psychiatric disorder.

Sickness – means an illness or disease which is diagnosed or treated by a Physician. The illness or disease must manifest itself during a Covered Activity.

Usual and Customary Charge(s) – means a charge that: (1) is made for a Covered Sickness Medical Service; (2) does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

Limitations

Limitation on Multiple Benefits. If You suffer one or more losses from the same accident for which amounts are payable under more than one of the following Benefits provided by the Policy, the maximum amount payable under all of the Benefits combined will not exceed the amount payable for one of those losses, the largest: Accidental Death Benefit, Accidental Dismemberment Benefit.

Aggregate Limit. The aggregate limit of indemnity for which the Company shall be liable with respect to Injuries sustained by more than one covered person under the Policy as a result of the same accident will not exceed the amount shown as the Aggregate Limit in the Benefit Schedule. If the combined maximum amount otherwise payable for all Insureds under the Policy must be reduced to comply with this provision, the reduction will be taken by applying the same percentage of reduction to the individual maximum amount otherwise payable for each Insured for all such losses under all those Benefits combined.

Exclusions

No coverage shall be provided under the Policy and no payment shall be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks.

1. suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury or autoeroticism.

2. sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these.

3. Your commission of or attempt to commit a crime.

4. infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes.

5. declared or undeclared war, or any act of declared or undeclared war, except if specifically provided by the Policy.

6. participation in any team sport or any other athletic activity, except participation in a Covered Activity.

7. 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 You are not covered due to Your 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).

8. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if You are:

    a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
    b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    c. riding as a passenger in an aircraft owned, leased or operated by the Policyholder or Your employer.

9. You being under the influence of intoxicants.

10. You being under the influence of narcotics unless taken under the advice of and as specified by a Physician.

11. the medical or surgical treatment of sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from the treatment.

12. stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm.

13. any condition for which You are entitled to benefits under any Workers' Compensation Act or similar law.

14. You riding in or driving any type of motor vehicle as part of a speed contest or scheduled race, including testing such vehicle on a track, speedway or proving ground.

15. any loss incurred while outside the United States, its Territories or Canada.

Excess Benefits

Accident Medical Expense or Sickness Medical Expense Benefits, are payable only in excess of expenses payable under any other valid and collectible insurance.

Penalty for Non-Compliance. If Your benefits under the Policy are payable in excess of other coverage and You have other coverage that is primary under a health maintenance organization, preferred provider organization or similar health service program, a penalty will apply if You do not use the facilities or services of the health maintenance organization, preferred provider organization or similar health service program. In such case, the benefits otherwise payable under the Excess provision in the Policy will be reduced by 50%. This reduction shall not apply to emergency treatment required within 24 hours of an accident when the accident occurs outside the geographic area served by a health maintenance organization, preferred provider organization or similar health service program.

Subrogation and Right of Recovery

As a condition to receiving Accident Medical Expense, Emergency Evacuation, Repatriation of Remains benefits under the Policy, You (or, if You are deceased, an authorized representative of Yours) agrees, except as may be limited or prohibited by applicable law:

1. to reimburse the Company for any such benefits paid to or on Your behalf, if such benefits are recovered, in any form, from any Third Party or Coverage. The Company's right of recovery will be secondary to Your right to be fully compensated for Your damages, if required by the jurisdiction in which the recovery action occurs; and

2. without limiting the preceding, that the Company is subrogated, for the purpose of the Company's recovery of any such benefits paid to or on Your behalf, to any and all claims, causes of action or rights that You have or that may rise against any Third Party who has or may have caused, contributed to or aggravated the injury or condition for which You claim an entitlement to Policy benefits, and to any claims, causes of action or rights You may have against any Coverage for the injury or condition for which You claim an entitlement to Policy benefits. The Company's right of subrogation will be secondary to Your right to be fully compensated for Your damages, if required by the jurisdiction in which the recovery action occurs.

You agree that You will make a decision on pursuing any and all claims, causes of action and rights against any and all Third Parties and Coverage within 30 days of the date the Company requires that You provide Notice of Claim for the injury or condition for which such Policy benefits are sought, and within such 30-day period will so notify the Company in writing. In the event You decide not to pursue a claim, cause of action or right against a Third Party or Coverage, or fail to notify the Company of Your intent to do so within such 30-day period, You authorize the Company to pursue, sue, compromise or settle any such claim, cause of action or right in Your name, authorize the Company to execute any and all documents necessary to pursue any such claim, cause of action or right, and agree to cooperate fully with the Company in the prosecution of any such claim, cause of action or right.

If You are a minor or are not competent to make this agreement, the legal guardian of Your property makes the agreement on Your behalf as a condition to receiving Accident Medical Expense, Emergency Evacuation, Repatriation of Remains benefits under the Policy on Your behalf. If You have no guardian for Your property, the person or persons who, in the Company's opinion, have assumed the custody and support of the minor or responsibility for the incompetent person's affairs make the agreement on Your behalf as a condition to receiving such benefits under this Policy on behalf of You.

If required by jurisdiction in which the recovery action occurs, the Company will pay its share of any fees or costs associated with the pursuit of a claim, cause of action or right by or on Your behalf against any Third Party or Coverage if the Company seeks recovery or subrogation.

Definitions. The following are additional definitions that apply to Subrogtation and Right of Recovery.

Coverage - means no fault motorist coverage, uninsured motorist coverage, underinsured motorist coverage, or any other fund or insurance policy (except this Policy and any fund or insurance policy providing the Policyholder with coverage for any claims, causes of action or rights You may have against the Policyholder).

Third Party(ies) - means any person, corporation or other entity (except You, the Policyholder and the Company).

CLAIMS PROVISIONS

Claims Procedures. All claims should be reported to the Company as soon as possible at the following phone number: 800-551-0824 or 302-761-3700.

Provide the policy number and details describing the nature of the loss.

Notice of Claim. Written notice of claim must be given to the Company within 20 days after Your loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company at AIG, Accident and Health Claims, P.O. Box 25987, Shawnee Mission, KS 66225, with information sufficient to identify You, is deemed notice to the Company.

Claim Forms. The Company will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include Your name, the Policyholder's name and the Policy number.

Proof of Loss. Written proof of loss must be furnished to the Company within 90 days after the date of the loss. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Company may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Payment of Claims. Upon receipt of due written proof of death, payment for loss of Your life will be made, in equal shares, to the survivors in the first surviving class of those that follow: Your (1) spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is Your estate.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) You. If You die before all payments due have been made, the amount still payable will be paid, in equal shares, to the survivors in the first surviving class of those that follow: Your (1) spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is Your estate.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee’s property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 may be made, at the Company’s option, to any relative by blood or connection by marriage of the payee who, in the Company’s opinion, have assumed the custody and support of the minor or responsibility for the incompetent person’s affairs.

Upon receipt of due written proof of loss, benefit payments for charges incurred by You for covered medical services may be made directly to the provider at the Company’s option. If any such charges have been paid by You, the benefit payment for those charges will be made to You upon written proof of payment.

Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

Time of Payment of Claims. Benefits payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon the Company’s receipt of due written proof of the loss. Subject to the Company’s receipt of due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the

period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

IMPORTANT

If any conflict should arise between the contents of this Description of Coverage and the Master Policy SRG 0009157733, or if any point is not covered herein, the terms and conditions of the Master Policy will govern in all cases.

SUMMARY OF THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are required by law to be members of the Louisiana Life and Health Insurance Guaranty Association (LLHIGA). The purpose of LLHIGA 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 happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The Louisiana Life and Health Insurance 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 upon residence in this state. Other conditions may also preclude coverage.*

Insurance companies and insurance agents 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 the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA
P.O. Box 3337
Baton Rouge, LA 70821

Department of Insurance
P.O. Box 94214
Baton Rouge, LA 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth at R.S. 22:2081 *et seq.* The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the law or the rights or obligations of LLHIGA.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well even if they live in another state unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.

Exclusions From Coverage

A person who holds a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA if:

1) He is 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.);

2) The insurer was not authorized to do business in this state;

3) His policy was issued by a profit or 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 policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA also does not provide coverage for:

1) Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

2) Any policy of reinsurance (unless an assumption certificate was issued);

3) Interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;

4) Dividends, premium refunds, or similar fees or allowances described under the Law;

5) Credits given in connection with the administration of a policy by a group contract holder;

6) Employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;

7) Unallocated annuity contracts (which gives rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans qualified under section 403(b) of the United States Internal Revenue Code (26 U.S.C. §403(b)).

8) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law.

9) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part C coverage" or "Medicare Part D coverage" and any regulations issued pursuant to those parts;

10) Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

Limits On Amounts Of Coverage

The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following.

1) LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.
2) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.
3) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any one individual.