www.wellaway.com

AVI GOLD SP

Policy Terms and Conditions

8/2018

Table of Contents

Health Care Coverage and Benefits 4

Provider Network - United States 5

Description of Benefits 7

Eligibility 15

Exclusions & Limitations 16

Definitions 19

Claims Administrative Procedures 27

General Provisions 31

Claims Appeal Procedures 34

To File a Complaint 34

Our Contact Numbers 34

SUMMARY OF BENEFITS

This policy is designed to provide coverage in the event of a medical emergency. This insurance will not cover expenses for the treatment of pre-existing conditions. All benefits are subject to the limitations and exclusions set forth in your policy. We encourage you to read your policy in its entirety before you seek health care services.

COST SHARE	
In-network or out-of-network non-emergency room visits	$150 co-pay
In-network & out of network provider	100% reasonable and customary
INPATIENT CARE (BENEFIT PERIOD)	
6 months or more	Unlimited
3 to 6 months	Unlimited
Less than 3 months	Unlimited
INPATIENT MENTAL ILLNESS BENEFIT	
6 months or more	$550
3 to 6 months	$275
Less than 3 months	Not covered
PHYSIOTHERAPY AND CHIROPRACTIC SERVICES	
6 months or more	$400
3 to 6 months	$200
Less than 3 months	$200
EMERGENCY DENTAL (PAIN RELIEF) / **DENTAL ACCIDENT**	
6 months or more	$800
3 to 6 months	$400
Less than 3 months	$200
Orthodontics (due to an accident)	$600 per tooth
Emergency medical evacuation	Unlimited
Emergency local transportation	Unlimited
Return of mortal remains	Unlimited
EMERGENCY MEDICAL REUNION	
Hospitalization - 3 day stay	$2,000 maximum
Hospitalization - 7 day stay	$4,000 maximum
Emergency return to home country (applicable 5 months or more)	Unlimited
ADDITIONAL BENEFITS	
Accidental death	$15,000
Disability (accident) applicable 6 months or more	Up to $75,000 maximum
Baggage and personal effects	$3,000 maximum
Personal effects	$1,000 maximum
Property (such as cameras)	$500 maximum per item
THIRD PARTY LIABILITY (BENEFIT LIMITS COMBINED)	
Personal injury	$100,000 combined maximum
Property damage	$100,000 combined maximum
Legal expenses	$100,000 combined maximum
Cosmetic surgery (due to accident only)	$17,000 maximum

All benefits are subject to reasonable and customary charges.
Failure to utilize the administrator to arrange for these services will result in the denial of benefits.

Health Care Coverage and Benefits

Scope of Coverage
Benefits are payable under this Policy for Eligible Expenses incurred by an Insured Person for the Eligible Benefits stated in the Summary of Benefits. Benefits will be payable to either the Participant or the Service Provider for Eligible Expenses incurred outside the Participant's Home Country. Coverage is available while at the Participant's destination.

The benefits enumerated herein will in no event include any amounts that are in excess of Reasonable and Customary Charges. If the charge incurred is in excess of the Reasonable and Customary charge, such excess amount will not be recognized as an Eligible Expense. All charges will be deemed to be incurred on the date of such Services or Supplies, which give rise to the expense or charge, are rendered or obtained.

We will provide the benefits described in this Policy to all Insured Persons for all Eligible Benefits set forth in the Description of Benefits section of this Policy.

Summary of Benefits
If an Injury or Illness to the Insured Person results in His incurring Eligible Expenses for any of the Services in the Summary of Benefits, We will pay the Eligible Expenses incurred, subject to any applicable Deductible, Copayments, Coinsurance, and any other limitations set forth in this Policy.

The Insured Person must be under the care of a Physician when the Eligible Expenses are incurred. The Eligible Expense must be incurred solely for the Treatment of a covered Injury or Illness while the person is an Insured Person under this Policy during the Benefit Period stated on your Certificate of Coverage. The total of all medical benefits payable under this Policy is subject to the specific maximums shown on your Summary of Benefits. All coverages and costs listed in the Summary of Benefits are in US Dollar amounts.

Pre-Certification and Network Procedures
Pre-certification is a process by which an Insured Person obtains approval for certain non-emergency medical procedures prior to the commencement of the proposed Procedure. This requires that the Insured Person request a pre-certification from the Administrator at least five (5) business days prior to the scheduled Procedure date, unless a greater time period is required as stated in this Policy. Complete medical records must be submitted to the Administrator for review of Medical Necessity in accordance with the terms of this Policy.

1) Pre-certification - You or someone on Your behalf are required to contact the Administrator in the following situations:

    a. Within 48 hours of an Emergency Hospital admission in the United States.

    b. Before an Inpatient Surgery in the United States.

    c. Prior to any Services that may result in emergency medical evacuation, repatriation or curtailment.

Note: Pre-certification does not guarantee that benefits will be paid. Failure to pre-certify benefits may result in a 50% co-payment.

Provider Network-United States

In-Network Provider: The Insurer reserves the right to require the use of an In-Network Provider where available. When utilizing an In-Network Provider, Insurer will reimburse the Eligible Expenses after all other applicable Cost Share amounts are applied.

Preferred Providers: We have designated certain Providers as Preferred Providers for the Treatment of certain conditions in order to reduce your Out-of- Pocket costs and obtain significant savings. In order to be covered, certain Services must be rendered by a Preferred Provider designated solely by us, except when such Services are Emergency Services for the Treatment of an Emergency medical condition. The Services that must be rendered by a Preferred Provider for the Treatment of certain medical conditions (which are only eligible if you have been approved for coverage for the Treatment of these medical conditions), are as follows:

- Aids
- Amputations
- Cancers
- Cardiovascular conditions
- Cerebrovascular conditions (CVA, Stroke)
- Chronic respiratory conditions
- Coma
- Diabetes
- End stage renal disease
- Hemophilia
- Immune system deficiencies
- Major burns-3rd degree
- Major head Injuries
- Multiple fractures and/or trauma
- Multiple Sclerosis
- Neurological disorders
- Spinal cord Injuries

Note: This list is not all inclusive and is intended only as a guide.

You are responsible for checking to see if you are covered for any of the medical conditions listed above and if a Provider is a Preferred Provider prior to receiving Services. To find out if you are covered and if a Provider is a Preferred Provider you should contact a ConciergeCare Counselor via the telephone number on your Identification Card or via email at avistudents@payerfusion.com. Utilizing an In-Network Provider or Preferred Provider does not guarantee benefits or that the treating facility will directly bill the Administrator.

Out-of-Network Provider: When an In-Network Provider is available within a 50-mile radius of your local residence and you choose not to use the In-Network Provider, claims will be reimbursed at the applicable Out-of-Network Provider amount as specified under your Summary of Benefits. Benefits payable are limited to the Reasonable and Customary Charges for the Services received or may be limited to the negotiated rate of a similarly situated In-Network Provider. If a discount is negotiated with the Provider, the savings realized will be passed on to you.

Out-of-Area Provider: If there is no In-Network Provider located within a 50-mile radius of your local residence, we will reimburse you the Eligible Expenses after applicable Cost Share amounts have been applied. The claim will be paid as In-Network subject to Reasonable and Customary Charges or at the rate of a similarly situated In-Network Provider. For information on the Providers, Physicians and Hospitals in the Network, you may log into your member portal at www.wellaway.com or contact your ConciergeCare Counselor via email at avistudents@payerfusion.com or by dialing USA toll-free and via Skype from anywhere in the world: +1.888.959.2296 and outside the USA (call collect) +1.786.558.2033.

You may also contact a ConciergeCare Counselor to determine the most suitable location to obtain Services based on:

1. Your residence location;
2. Nature of symptom and signs; and
3. Possible Emergency or urgency of your needs.

Our ConciergeCare Counselor team is highly experienced in identifying the level of care that your current situation may require and could effectively guide you to the most appropriate Facility or Physician, either Primary Care, Secondary Care or Tertiary Care. To assess your situation, a ConciergeCare Counselor will ask you a simple set of questions which will assess and determine the best level of care. There are three main levels of care as follows:

Primary Care
Most of us are very familiar with primary care. That is our first - and most generalized - stop for symptoms that are new to us or concerns that we have contracted a cold, flu or other bacterial or viral disease. We may also seek out primary care for a broken bone, a sore muscle, a skin rash or any other acute medical problem we think we have developed. Primary care providers (PCPs) may be doctors, nurse practitioners or physician assistants. There are some primary care "specialties" like OB-GYNs, geriatricians and pediatricians

Secondary Care
If you have ever seen a specialist after being referred by a PCP, then you have been referred for secondary care. Secondary care simply means you will be taken care of by someone who has more specific expertise in whatever problem you are having. Specialists focus either on a specific body system or on a specific disease or condition. For example, cardiologists focus on the heart and its pumping system. Endocrinologists focus on our hormone systems and some specialize in diseases like diabetes or thyroid disease. Oncologists work on cancers. Secondary care is where most of us end up when we have a medical condition to deal with that cannot be handled by a PCP. Sometimes, problems with specialty care develop because we have been referred to the wrong type of specialist. Secondary care also includes non-simple diagnostic tests ordered by one of these specialists to further diagnose your medical condition. Tests such as MRI, CAT scans, PET scans and other specialty x-rays are considered to be secondary care.

Tertiary Care
Tertiary care refers to those Services where a patient needs and requires hospitalization and needs a higher level of specialty care within the Hospital. Tertiary care requires highly specialized equipment and expertise such as coronary artery bypass Surgery, renal or hemodialysis, some Surgeries or neurosurgeries, severe burn treatments or any other very complex Treatments or Procedures.

Description of Benefits

Medical Expenses

We may pay Reasonable and Customary Charges for Eligible Expenses, in excess of the Cost Share amounts, up to the Maximum Benefit, incurred by an Insured Person due to an Accidental Injury or Illness which occurred during the Benefit Period outside the Insured Person's Home Country. The initial Treatment of an Injury or Illness must occur within thirty (30) days of the date of Injury or onset of Illness. Utilizing a hospital emergency room for NON-Emergency care will result in additional expenses and out of pocket costs. Only such expenses which are specifically enumerated in the following list of charges and incurred within thirty (30) days from the date of the Accident or onset of the Illness and which are not excluded may be considered Eligible Expenses:

<u>Inpatient Care</u>:

1. Charges made by a Hospital for room and board, floor nursing and other Services inclusive of charges for professional Services and with the exception of personal services of a non-medical nature; provided, however, that such expenses do not exceed the Hospital's average charge for semi-private room and board accommodations.
2. Charges made for Intensive Care and nursing services.
3. Charges made for diagnosis, Treatment and Surgery by a Physician. Note: Surgery that is not prescribed by the Surgeon and which is not performed by the Surgeon within ten (10) days of the Accident or the diagnosis of the Illness, is not considered an Emergency and is not covered.
4. Charges made for an operating room.
5. Charges made for the cost and administration of anesthetics.
6. Charges for medication, x-ray services, laboratory tests and Services, the use of radium and radioactive isotopes, oxygen, blood, transfusions, iron lungs, and Medical Treatment.
7. Charges for physiotherapy if recommended by a Physician for the Treatment of a specific Disablement and administered by a licensed physiotherapist (if covered under your plan).
8. Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon. Cosmetic Surgery prescribed by a plastic Surgeon resulting from a covered Accident (not Illness) in an amount not to exceed $17,000 USD. The benefit amount will be determined by the Insurer's medical director, at its sole discretion.
9. Emergency local transportation to or from the nearest Hospital or to and from the nearest Hospital with facilities for required Treatment. Such transportation shall be by licensed ground ambulance within the metropolitan area in which the Insured Person is located at that time the Service is used. If the Insured Person is in a rural area, then licensed air ambulance transportation to the nearest metropolitan area may be considered an Eligible Expense up to the Maximum Benefit.

<u>Notes:</u>

1. Inpatient Care benefits will be paid in accordance with the benefit limits set forth in your Summary of Benefits.
2. If Surgery is necessary for the Insured Person to carry out His normal activities, but not a medical Emergency, the Insurance Company has the option, in its sole discretion, to return the Participant to His Home Country for the Surgical Procedure and for all necessary rehabilitation; provided, however, (i) Your Policy must have a Benefit Period for five (5) months or more; and (ii) You have more than thirty (30) days remaining prior to Your original scheduled return, or You must return to the Host Country to take an examination required for future studies. In such case, the benefits payable will include the cost of roundtrip economy airfare which must be used within three (3) months from the date of the Surgeon's order and within the program.
3. For purposes of this Policy, assault is considered an Accident and covered under the Medical Expenses benefit of this Policy.
4. In the event the Hospital Stay is longer than the Benefit Period under the Policy, the Insurance Company will only cover the medical expenses beyond the original Benefit Period if: (i) the Insured Person purchases additional coverage in accordance with this Policy; (ii) for a period not to exceed thirty (30) days; and (iii) for the sole purpose of stabilizing medical Treatment. The Insurance Company has the option, in its sole discretion, to return the Participant to His Home Country. Coverage is limited to life-threatening stabilization only. No additional coverage for an unrelated Illness, complications or a secondary diagnosis.
5. All benefits are subject to the Exclusions and Limitations section of this Policy.
6. This benefit must be approved by the Administrator. Failure to utilize the Administrator to arrange for these Services will result in the denial of benefits.

Dental (Accident)

This Policy may pay in excess of the applicable Cost Share amounts, up to the Maximum Benefit stated in your Summary of Benefits,

for Emergency Treatment for Services of a dentist or oral surgeon to Sound Natural Teeth as the result of a covered Accident (only those Injuries caused by external contact with a foreign object are covered). In addition, Emergency Treatment for orthodontic Services, up to the Maximum Benefit stated in your Summary of Benefits, will also be provided resulting from an Accident; provided, however, if the orthodontic treatment is not performed in the Host Country due to Your condition or age within thirty (30) days from the date of the Accident, this Policy will be secondary to any other health benefit plan in Your Home Country.

Notes:

1. Dental benefits (Accident) will be paid in accordance with your Benefit Period and the benefit limits set forth in your Summary of Benefits.
2. This benefit must be approved by the Administrator. Failure to utilize the Administrator to arrange for these Services will result in the denial of benefits.

Exclusions:

1. Broken or chipped teeth, loosened or lost filings/amalgams while eating, chewing and biting are not, at any time, considered an Accident or a result of an Accident under the terms of this Policy.
2. All Dental benefits are subject to the Exclusions and Limitations section of this Policy.

Emergency Dental (Pain Relief)

This Policy may pay in excess of the applicable Cost Share amounts, up to the Maximum Benefit stated in your Summary of Benefits, for Emergency Treatment for the relief of pain to Sound Natural Teeth or infection of the gums. Any follow-up treatment may be covered up to a maximum amount of $100 USD. All dental claims must include an x-ray of the concerned tooth/gum. X-rays will be reimbursed at the customary cost charged in the geographic area where the dentist who provided the dental care is located.

Notes:

1. Emergency Dental (pain relief) benefits will be paid in accordance with your Benefit Period and the benefit limits set forth in your Summary of Benefits.
2. This benefit must be approved by the Administrator. Failure to utilize the Administrator to arrange for these Services will result in the denial of benefits.

Exclusions:

1. You are not covered if you break a tooth while eating or biting into a foreign object.
2. No coverage is provided for claims submitted without the mandatory x-ray film.
3. No coverage is provided for routine dental examinations, Pre-Existing Conditions, including, but not limited to cavities, restorative work, orthodontics, dental equipment, crown build up, crowns, reconstructive work or all other Treatments unrelated to pain alleviation.
4. All Dental benefits are subject to the Exclusions and Limitations section of this Policy.

Inpatient Mental Illness Benefit

Only such expenses, incurred as the result of Treatment or medication from the onset of Mental Illness as an Inpatient, which are specifically enumerated in the following list of charges, and which are not excluded, may be considered as Covered Expenses:

1. Charges made by a Hospital or mental institution for room and board, floor nursing and other services inclusive of charges for professional services and with exception of personal services of a non-medical nature, provided, however; that expenses do not exceed the Hospital's or mental institution's average charge for semi-private room and board accommodation.
2. Charges made for diagnosis and Treatment by a Physician.
3. Charges made for the cost and administration of anesthetics.
4. Charges for medication, x-ray services, laboratory tests and services, oxygen, and Medical Treatment.
5. Drugs and medicines that can only be obtained upon a written prescription from Physician.

Notes:

1. Inpatient care benefits shall be payable in accordance with the amounts set forth in your Summary of Benefits.
2. For any Benefit Period which is less than three (3) months, there is no coverage for Inpatient Mental Illness.
3. For any Benefit Period which is three (3) to six (6) months, the benefit limit is $275 USD for Inpatient Mental Illness.
4. For any Benefit Period that is more than six (6) months, the benefit limit is $550 USD for Inpatient Mental Illness.
5. Mental Illness must first manifest itself during the Benefit Period.
6. All benefits are subject to the Exclusions and Limitations section of this Policy.
7. This benefit must be approved by the Administrator. Failure to utilize the Administrator to arrange for these Services will

result in the denial of benefits.

Physiotherapy and Chiropractic Services

Benefits shall be paid for physiotherapy which is prescribed by a Physician and administered by a licensed physiotherapist. Chiropractic Services may be covered if prescribed by a Physician to relieve back pain and accompanied by the proper x-rays and other images that need to be taken in order to confirm such Services are Medically Necessary. The Administrator will allow for three (3) sessions without a Treatment plan. Any additional sessions beyond the initial three (3) sessions is subject to a Treatment plan indicating the frequencies and duration by the Physician.

Notes:

1. Please refer to your Summary of Benefits for the benefits under your plan.
2. For any Benefit Period which is six (6) months or less, the benefit limit is $200 USD for both physiotherapy and chiropractic Services combined.
3. For any Benefit Period which is more than (6) months, the benefit limit is $400 USD for both physiotherapy and chiropractic Services combined.
4. All benefits are subject to the Exclusions and Limitations section of this Policy.
5. This benefit must be approved by the Administrator. Failure to utilize the Administrator to arrange for these Services will result in the denial of benefits.

Emergency Medical Evacuation

In the event of a life-threatening Emergency, when appropriate Treatment is not available locally, this Policy provides Emergency Medical Transportation to the closest medical Facility capable of providing the required care up to the Maximum Benefit shown in your Summary of Benefits. Should Treatment be available locally, but the Insured Person chooses to be treated elsewhere, transportation expenses shall be the responsibility of the Insured Person. In the event of such Emergency, the Administrator reserves the right to determine the medical Facility to which the Insured Person shall be transported and the means of transportation. If the Insured Person chooses not to be treated at the Facility and location arranged by the Administrator, the transportation expenses shall be the responsibility of the Participant or Insured Person. Following completion of the Treatment and if medically able, the Insurer will also cover the cost of the return trip, at economy rates, for the evacuated Insured Person to return to his/her Home Country.

Notes:

1. This benefit must be approved by the Administrator. Failure to utilize the Administrator to arrange for these Services will result in the denial of benefits.
2. Emergency Medical Evacuation will only be authorized when the Insured Person is deemed fit to fly. If the Insured Person refuses to be evacuated when declared medically fit to travel, any additional expenses incurred after such refusal shall be the responsibility of the Participant or Insured Person.
3. If the Insured Person is not declared medically fit to travel by the Expiration Date, any additional expenses incurred after Expiration Date shall be the responsibility of the Participant or Insured Person.
4. All benefits are subject to the Exclusions and Limitations section of this Policy.

Exclusion: Emergency Medical Evacuation arising out of any Illness or Injury while on a cruise ship is excluded from coverage under this Policy. For cruise travel, we recommend that you purchase cruise travel insurance with cruise travel evacuation and disembarkation.

Return of Mortal Remains

In the event of death from an Accidental Injury or Illness, this Policy will provide coverage for: (i) the cost of transportation of the body or ashes of an Insured Person to his/her Home Country, including all necessary documentation; or (ii) the cost of sending the urn to the Home Country. Please review your Summary of Benefits for Maximum Benefit amounts.

Limitations: This benefit is subject to the following limitations:

1. Coverage is limited to expenses for embalming, a container legally appropriate for transportation, shipping costs and necessary government authorizations.
2. Funeral costs are not covered.
3. The original death certificate must be provided along with copies of any payment of cremation Services of the Insured Person when a request for Reimbursement is made.
4. This benefit must be approved by the Administrator. Failure to utilize the Administrator to arrange for these Services will result in the denial of benefits.

5. All benefits are subject to the Exclusions and Limitations section of this Policy.

Emergency Medical Reunion

We will arrange and pay up to the Maximum Benefit stated in your Summary of Benefits for roundtrip economy- class transportation and hotel accommodations for the following:

1. If the Insured Person's Hospital Stay is planned to last more than three (3) days, one (1) individual of the Insured Person's choice, from His Home Country, to be at the Insured Person's side while the Insured Person is hospitalized up to the maximum amount of $2,000 USD, including the cost of lodging (the cost of lodging cannot exceed $100 USD per day for a maximum of 15 days).
2. If the Insured Person's Hospital Stay is planned to last more than seven (7) days, two (2) individuals of the Insured Person's choice, from His Home Country, to be at the Insured Person's side while the Insured Person is hospitalized up to the maximum amount of $4,000 USD, including the cost of lodging (the cost of lodging cannot exceed $150 USD per day for two individuals for a maximum of 15 days).

The benefits payable will include: (1) the cost of a roundtrip economy airfare; and (2) reasonable travel and accommodation expenses incurred in relation to the Maximum Benefit stated in the Summary of Benefits.

<u>Notes:</u>

1. The period of emergency medical reunion is not to exceed 15 days, including travel. Any expenses past the 15 days allowed by this Policy will become the sole responsibility of the Insured Person and/or companion.
2. This benefit must be approved and arranged by the Administrator. Failure to utilize the Administrator to arrange for these Services will result in the denial of benefits.
3. All benefits are subject to the Exclusions and Limitations section of this Policy.
4. The companion(s) must return home no later than five (5) days after the Insured Person is discharged from the Hospital. The date of discharge will be determined by the Hospital invoice.

Emergency Return to Home Country

When there is an Accidental death, life-threatening Accident, or life-threating Illness of a Family Member after You arrive in the Host Country and You are not able to use your original return ticket to your Home Country, We will arrange and pay up to the Maximum Benefit stated in your Summary of Benefits for roundtrip economy-class transportation to your Home Country.

<u>Notes:</u>

1. This benefit is only payable if: (i) Your Policy has a Benefit Period for five (5) months or more; and (ii) You have more than thirty (30) days remaining prior to Your original scheduled return, or You must return to the Host Country to take an examination required for future studies.
2. All benefits are subject to the Exclusions and Limitations section of this Policy.
3. This benefit must be approved by the Administrator. Failure to utilize the Administrator to arrange for these Services will result in the denial of benefits.

Accidental Death

Benefits may be paid if You sustain an Accidental death during the Benefit Period. Benefits payable for any such Loss will be the amount of $15,000 for loss of life. Compensation for the Accidental death of an Insured Person will be paid to the Insured Person's natural parents or to the parent who registered the Insured Person to the stay or to the legal heirs.

<u>Notes:</u>

1. This benefit, as well as repatriation of remains, will not be paid if the Insured Person's cause of death is expressly excluded as set forth in the Exclusions and Limitations section of this Policy.
2. In the case of death related to a covered Illness, only repatriation of remains will be covered.

Disability Resulting from an Accident

In the event of a disability resulting from an Accidental Injury (not Illness), this Policy will pay a percentage of the Maximum Benefit amount outlined in your Summary of Benefits. This is based on the injury loss outlined in Disability Table below. If a Third Party is responsible for the Accident leading to your disability, the Insurer will advance the disability payments to you and will exercise any and all of its rights of subrogation.

Disability payable percentage for Injuries:

Loss Description	Percentage of Principal Sum
Loss of Life	100%
Loss of Speech and Loss of Hearing	100%
Loss of Speech and one Loss of Hand, Loss of Foot or Loss of Sight of One Eye	100%
Loss of Hearing and one Loss of Hand, Loss of Foot or Loss of Sight of One Eye	100%
Loss of Hands (both), Loss of Feet (both), Loss of Sight or a combination of any two of Loss of Hand, Loss of Foot or Loss of Sight of One Eye	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Loss of Hand, Loss of Foot or Loss of Sight of One Eye (any one of each)	50%
Uniplegia	25%
Loss of Thumb and Index Finger of the same hand	25%

Note:

1. This benefit is not available to a disability resulting from an Illness.
2. This benefit will not be paid if the Insured Person's cause of disability is expressly excluded as set forth in the Exclusions and Limitations section of this Policy or if the disability is the result of an Illness.

Baggage and Personal Effects

Always take special care to protect Your valuable property by locking it in a safe place when not in use. In the event Your personal belongings are damaged or lost solely due to theft, robbery, assault, traffic Accident or transportation company mishandling while You are traveling to and from your program, we will pay up to the Maximum Benefit stated in your Summary of Benefits.

Transportation Company Mishandling

When luggage/baggage damage or loss occurs due to transportation company's mishandling, the Insurance Company acts as a secondary insurance carrier. The primary coverage is provided by the transportation company. A claim must immediately be filed with the transportation company. The amount not reimbursed by the transportation company may then be claimed with the Insurance Company. If the transportation company denies Your claim based on the fact that You did not file a claim or that the claim was not filed in a timely manner, we will also deny Your claim since we are secondary to the transportation company.

Host Family Coverage

In the event Your personal belongings are damaged or lost solely due to theft, robbery, assault, or traffic Accident while in your host family's residence or property, we will pay up to the Maximum Benefit stated in your Summary of Benefits only if your host family's homeowners or automobile insurance carries a deductible or if your belongings are not covered under such Policy.

Notes:

1. If you are en route or are staying at a campus dormitory or hotel, only fire or water damage is reimbursed, since the primary theft insurance is provided by the hotel or dormitory facility.
2. In case of a robbery, you must immediately report the Loss to the police, transportation company, hotel, etc.
3. You must provide a copy of the report to the Insurer or Administrator along with Your request for reimbursement. Only an official theft/loss or police report will be accepted by the Insurer. It is the Insured Person's responsibility to submit a comprehensive police report. This is mandatory in order to process Your claim. In filing a claim for property, you must also provide a detailed description of the property along with its date of purchase and value. Bills, invoices or other proof of value are required. Stolen or damaged property will be valued allowing for wear and tear at the time of the Loss.
4. Only in case of an assault or theft will ID cards, driver's license, or passport be reimbursed.
5. You have 5 days to send your claim from the date your property was lost/stolen/damaged.

Property not covered: musical instruments, bicycles, weapons and hunting gear (even when borrowed), lost or abandoned property, glasses, contact lenses, artificial limbs/prosthesis, all means of payment (check, credit card, coins, currencies), stamps, manuscripts, concert tickets, legal/professional documents, all transportation tickets, keys, cellular phones, animals, motor-driven vehicles, boats,

Exclusions: No coverage is provided for the following:

1. if jewels are lost in the course of sports or if they are not worn.
2. if the theft occurs from unlocked premises.
3. if property is left anytime in a convertible, a tent or in a trailer.
4. if property is visible in the interior of any car.
5. if property is left from 10 p.m. to 7 a.m. in any car.
6. if the car was not broken into.
7. for normal wear and tear or due to atmospheric influences.
8. for damage due to moths and rodents.
9. for damage due to unsuitable packing.
10. for property confiscated by any governmental authority.
11. for loss of I.D. cards, driver's license, or passport (unless you are a victim of an assault or theft), or loss of local transportation tickets.
12. for damage caused by carried liquids.
13. for damage caused by an Accidental fall.
14. due to the negligence of the Insured Person including, but not limited to, bags left unattended in public areas (e.g., premises to which more than you have access).

Third Party Personal Liability and Legal Expenses

Subject to the Maximum Benefit set forth in your Summary of Benefits, and subject to the Conditions and Exclusions set forth in this benefit below, Insurance Company will pay or reimburse the Insured Person for eligible court-entered judgments or Company-approved settlements arising as a result of or in connection with the personal liability of the Insured Person incurred for acts, omissions and other occurrences for:

1. Accidental Injury to a Third Party solely, directly and proximately caused by the negligent acts or omissions of the Insured Person during the Benefit Period; and/or
2. Damage or loss to a Third Party's personal property solely, directly and proximately caused by the negligent acts or omissions of the Insured Person during the Benefit Period.

With respect to covered and eligible personal liability claims set forth above, Insurance Company will pay the Insured Person for associated reasonable legal fees and out-of-pocket costs incurred by the Insured Person with respect to the determination and/or settlement of such legal liability.

Conditions:

1. The Insured Person must notify the Insurance Company within thirty (30) days of any act, omission or occurrence that may create or impose any personal liability upon the Insured Person, and also within thirty (30) days of the initiation or receipt of service of any actual or threatened lawsuit, notice of claim, or proceeding filed or threatened to be filed against the Insured Person with respect to same. In addition, such notification(s) to the Insurance Company shall include a recitation of all circumstances, facts, and known or presumed causes of any loss or damage, and a description of the nature and approximate amount of any damages suffered by any Third Party. In addition, immediately upon receipt thereof the Insured Person shall provide to the Insurance Company copies of any pleadings, complaints, lawsuits, petitions, demand letters, notices, orders, summonses, subpoenas, opinions, briefs, motions, letters from opposing counsel, and any other documents or papers with respect to any such lawsuit or proceeding that are received or issued by, addressed to or from, remitted to or by, or served by or upon the Insured Person or his/her counsel. Any failure to so notify or provide papers or documents to the Insurance Company in strict accordance with the foregoing shall be deemed to be and will result in a forfeiture and waiver of any and all benefits, claims or coverages otherwise provided by this Policy.
2. The Insurance Company shall have the absolute right and authority without further consent or approval of the Insured Person to intervene in its own name and on its own behalf as a party in interest with respect to any lawsuit, civil action or other proceeding in which the Insured Person is involved and for which the Insurance Company may have exposure for coverage or benefits under this Policy, and shall be entitled to fully participate, receive due and proper notice of all matters, and have an opportunity to be heard with respect to all issues, controversies and other proceedings or hearings of any kind. In addition, the Insurance Company shall have complete control over the legal proceedings and the appointment and control of a lawyer, if it deems necessary in its sole discretion. The Insured Person must follow the legal representative's advice and provide any and all information and assistance as required. Failure to do so will entitle the Insurance Company to withdraw cover.
3. With respect to any personal liability of the Insured Person for which He is or may be jointly or jointly and severally liable with other Third Parties, the Insurance Company shall be fully subrogated to all rights of contribution, indemnity, recoupment and

recovery of proportional shares from other joint tortfeasors whose negligence contributed in whole or in part to the subject Injury or Loss and who are or may also be liable to the Insured Person or the injured/damaged Third Party.

4. As a condition precedent to any liability or obligation of the Insurance Company to provide coverage or benefits for personal liability under this Policy, no settlement, compromise, accord, admission of fault or liability, default, default judgment, waiver, release, indemnity, hold harmless, or other concession of any kind shall be given, made, committed, allowed, granted or agreed to by or on behalf of the Insured Person to any Third Party without the prior express written approval and consent of the Insurance Company, and any failure to comply with this condition precedent shall void, waive and forfeit all benefits and coverage for legal assistance or coverage for personal liability under this Policy.
5. Insurance Company shall not be liable or obligated to provide any coverage or benefits or to pay or reimburse any claim, damage or loss under this Policy for, and no coverage or benefits shall be eligible or available under this Policy with respect to, any legal fees, legal costs or expenses, advancements of bail, or for any personal injury or property damage claims, liability awards or judgments in the event there exists any other insurance, insurance fund, membership benefits, workers' or workplace compensation coverage program or other similar governmental program, reimbursement or indemnification coverage, right of contribution, recoupment or recovery, contract, or any other third-party obligation or liability for provision of benefits ("Primary Coverage") which would, or would but for the existence of this Policy, be available or obligated to provide such benefit or to pay or reimburse or provide indemnity for such claim, damage or loss, except in respect of any excess beyond the amount payable or provided under such Primary Coverage had this Policy not been in effect. Further, the Insurance Company shall not be liable or obligated to provide any benefit or to pay or reimburse any claim for Injury, Loss or damage to the extent coverage for same is furnished or provided by any program or agency funded or controlled by any government or government authority.
6. No Third Party is intended to have, shall be deemed or construed to have, or shall have any rights or interest as a "third-party beneficiary" under this Policy, and any allegation or assertion of any such status, or any direct claim or other attempt to legally enforce alleged rights by such Third Party against the Insurance Company or the Administrator based on any allegation or assertion of any such status, shall be subject to summary dismissal. Notwithstanding any law, statute, judicial decision, or rule to the contrary which may be or may purport to be otherwise applicable within the jurisdiction, locale or forum state of any Insured Person or Third Party or the situs of any alleged personal Injury, property damage or other Loss, no transfer or assignment of any of the Insured Person's rights, benefits or interests under this Policy shall be valid, binding on, or enforceable against the Insurance Company or the Administrator unless first expressly agreed and consented to in writing by the Insurance Company, which agreement and/or consent may be refused and/or withheld for any or no reason at the sole discretion of the Insurance Company. Any such purported transfer or assignment not in strict compliance with the foregoing provisions of this section shall be void ab initio and without effect as against the Insurance Company and the Administrator and any assertion or claim of same shall be subject to summary dismissal, and the Insurance Company and the Administrator shall have no liability of any kind under this Policy to any such purported transferee or assignee with respect thereto.
7. The coverage limit is for any one event even if multiple Losses are incurred by multiple Insured Person's carrying this Policy.
8. This benefit is only available to Policies that have a Benefit Period for six (6) months or more.
9. This benefit will not be paid if the Insured Person's cause of liability is expressly excluded as set forth below and in the Exclusions and Limitations section of this Policy.

Exclusions: The Insurance Company shall not be liable for claims arising directly or indirectly from:

1. Employer's liability, contractual liability or liability to a Family Member, Relative, host family or traveling companion.
2. Animals belonging to or in the care, custody or control of an Insured Person.
3. Any willful, wanton, malicious, or unlawful act.
4. Pursuit of trade, business or profession.
5. Ownership or occupation of land or buildings.
6. Ownership, possession or use of vehicles, aircraft, or motor-powered watercraft.
7. The influence of intoxicating liquor, or the use of firearms.
8. Legal costs resulting from any criminal proceedings.
9. Any claims reported more than ninety (90) days after the commencement of the incident giving rise to such claim. Costs incurred in pursuance of any claim against a travel agent, tour operator, carrier, accommodation provider, the Insurance Company, its Administrator or agent, or any other person insured under the same Certificate of Coverage.
10. Legal expenses incurred prior to the granting of support by the Insurance Company.
11. Costs incurred in pursuance of a claim against any person with whom the Insured Person had arranged to travel.
12. Any claim whereby, in the Insurance Company's opinion, there is insufficient prospect of success in obtaining a reasonable benefit.
13. Any claim where legal costs and expenses are based directly or indirectly on the amount of an award.
14. The pursuit of any appeal except in the Insurance Company's determination, in its sole discretion.

15. Where there is a possibility of a claim being brought in more than one country the Insurers shall not be liable for the cost if an action is brought in more than one country.
16. The sponsoring organization cannot be considered a third party under the terms of this insurance. Should a dispute/lawsuit occur between you and your sponsoring organization, both in your Home and/or your Host country, no coverage would be provided under the third party liability or legal assistance benefits.

Eligibility

All non-US citizens who are students, visiting faculty, scholars, au-pairs, attending language schools, or participating in linguistic stays, homestays or other similar programs, age 12 or older who are temporarily residing outside their Home Country and are engaged in Full-Time Educational or Research Activities in the United States and have a valid J-1, H, F, M or Q visa or similar appropriate visa ("Eligible Individuals") are eligible for coverage under this Policy; provided, however, the Participant must remain engaged in Full- Time Educational or Research Activities outside their Home Country during the Benefit Period.

Notes:

1. We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, our only obligation is to refund any Premium paid for such Insured Person.
2. For students under the age of 18, the parent or legal guardian of the student must complete the documentation with the applicable sponsoring organization as follows:
    1) Parental Authorization Form completed and signed by the Parent or Guardian.
    2) Vaccination agreement.
    3) Student-Parent Agreement Form completed and signed by the Student and the Parent or Guardian.
    4) Student application completed and signed by the Student and the Parent of Guardian.
    5) Student behavior agreement.
3. For students under the age of 18, the parent or legal guardian is required to sign the application and purchase the policy on behalf of the student.

Effective Dates of Insurance

A person will become a Participant under this Policy, provided proper Premium payment is made, on the latest of:

1. The Effective Date of the Policy; or
2. The date the Insurer receives a completed application or enrollment form; or
3. The day He becomes eligible, subject to any required Waiting Period, according to the referenced date requested and shown in the application/enrollment form; or
4. The moment He departs his Home Country airspace.

Termination Date of Insurance

Insurance for a Participant will end on the earliest of:

1. The date He is no longer an Eligible Individual; or
2. The date the Participant returns to His Home Country; or
3. The expiration of 364 days from the Effective Date of coverage; or
4. The date shown on the Certificate of Coverage or Identification Card issued by the Insurer; or
5. The date the Participant becomes a permanent resident of the United States.

Additional Benefit Period

Participants may apply for a new Benefit Period, subject to the review and approval of the Insurer. The original effective date will be used with regards to determining any Pre-Existing Conditions. This option is available as long as the Participant continues to meet the eligibility requirements. It is important to note that rates and benefits may change for each subsequent Benefit Period. Extension requests must be received within five (5) days of expiry of the current Benefit Period. Coverage may be purchased for an additional ninety (90) days at a time. Prevailing rates will apply at the time of the request (not to be combined with any other policy to exceed this limit).

Exclusions and Limitations

No benefit shall be payable as the result of the following:

1) Any Pre-Existing Condition(s);
2) Injury or acute Illness which is not presented to the Administrator for payment within sixty (60) days of receiving Treatment;
3) Charges for Treatment which is not Medically Necessary;
4) Charges provided at no cost to You;
5) Charges for Treatment which exceeds Reasonable and Customary Charges;
6) Charges incurred for Surgery or Treatments which are Experimental/Investigational, or for research purposes;
7) Services, supplies or Treatment, including any period of Hospital confinement, which were not recommended, approved and certified as Medically Necessary and reasonable by a Physician;
8) Suicide or any attempt thereof, self-destruction, self-inflicted or attempt thereof while sane or insane (may vary by state of residence);
9) War, Terrorism, hostilities or warlike operations (whether war is declared or not), invasion, act of an enemy foreign to the nationality of the Insured Person or the country in, or over, which the act occurs, civil war, riot, rebellion, insurrection, revolution, overthrow of the legally constituted government, civil commotion assuming the proportions of, or amounting to, an uprising, military or usurped power, explosions of war weapons, Utilization of Nuclear, Chemical or Biological weapons of mass destruction howsoever these may be distributed or combined, murder or assault subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the Insured Person whether war be declared with that state or not. Also excluded herein is any Loss or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, or suppressing any, or all, of the situations described above. In the event any portion of this exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

For the purpose of this Exclusion:

a) Utilization of Nuclear weapons of mass destruction means the use of any explosive nuclear weapon or device or the emission, discharge, dispersal, release or escape of fissile material emitting a level of radioactivity capable of causing incapacitating disablement or death amongst people or animals.
b) Utilization of Chemical weapons of mass destruction means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing incapacitating disablement or death amongst people or animals.
c) Utilization of Biological weapons of mass destruction means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which are capable of causing incapacitating disablement or death amongst people or animals.

10) Injury sustained while participating in professional athletics, including but not limited to the event, games, practice, conditioning and any other activity related to professional athletics;
11) Routine physicals, immunizations or other examinations where there are no objective indications or impairment in normal health, and laboratory diagnostic or x-ray examinations, including vaccinations, expenses for glasses, contact lenses, hearing-aids, prosthesis, and artificial limbs.
12) Diagnosis or Treatment of the temporomandibular joint;
13) Expenses for vocational, occupational, sleep, speech, recreational or music therapy
14) Services, Supplies, or Treatment prescribed, performed or provided by a Relative of the Insured Person or any Family Member of the Insured Person or anyone who lives with the Insured Person. This includes, but is not limited to, prescription medication and any diagnostic testing;
15) Elective Surgery which can be postponed until the Insured Person returns to their Home Country, where the objective of the trip is to seek medical advice, Treatment or Surgery;
16) Treatment and the provision of false teeth or dentures or dental appliances, normal ear tests and the provision of hearing aids, hearing implants, dental expenses except as specifically provided in the Dental benefit;
17) Eye surgery, eye refractions, eye examinations, eye glasses, contact lenses, unless the result of Treatment for complications of

a covered Accidental Injury incurred during the Insured Person’s Benefit Period;

18) Cosmetic or plastic surgery (including deviated nasal septum), unless the result of Treatment for complications of a covered Accidental Injury incurred during the Insured Person’s Benefit Period up to the maximum benefit limit;
19) Treatment in connection with alcohol, drug or chemical abuse, misuse, illegal use, overuse or dependency or use of any drug or narcotic agent; Injury sustained while under the influence of or Disablement due wholly or partly to the effects of intoxicating liquor, chemicals, or drugs or narcotic agent, unless administered under the advice of a Physician and said narcotic agent was taken in accordance with the proper dosing as directed by the Physician, unless otherwise covered under this Policy;
20) Injury sustained or Disablement due wholly or partly to the effects of intoxicating liquor or drugs other than drugs taken in accordance with the proper dosing as directed by a Physician;
21) Any Mental and Nervous disorders or rest cures, unless otherwise covered under this Policy;
22) Learning disabilities, attitudinal disorders, or disciplinary problems;
23) Congenital abnormalities and conditions arising out of or resulting therefrom;
24) Expenses which are non-medical in nature;
25) Expenses as a result of, or in connection with, intentionally self-inflicted Injury or Illness;
26) Expenses as a result of, or in connection with, the commission of a criminal/illegal offense;
27) Injury sustained while taking part in recreational sports, Mountaineering, hang gliding, paragliding, Parachuting, bungee jumping, racing by any animal or Motor Vehicle or motorcycle, snowmobiling, motorcycle/motor scooter or recreational vehicle riding (whether as a passenger or driver), hunting, horse jumping, scuba diving involving underwater breathing apparatus, water skiing, wakeboard riding, jet skiing, windsurfing, ice hockey, boxing, martial arts, snow skiing and snowboarding (except for recreational downhill and/or cross country snow skiing or snowboarding. No cover provided while skiing/boarding in any violation of applicable laws, rules or regulations, away from prepared and market in-bound territories; and/or against the advice of the local ski school or local authoritative body); and any sport or athletic activity; use of any type of firearms (any device that discharges a projectile of any type);
28) Treatment paid for or furnished under any other individual or group policy or other service or medical pre- payment arranged through the employer to the extent so furnished or paid, or under any mandatory government program or facility set up for Treatment without any cost to You;
29) Pregnancy or Illness resulting from pregnancy, childbirth, or miscarriage; or for miscarriage resulting from an Accident or complications of pregnancy; or for postnatal care, unless otherwise covered under this Policy;
30) Drug, Treatment or procedure that either promotes or prevents conception, or prevents childbirth, including, but not limited to: artificial insemination, Treatment for infertility or impotency, sterilization or reversal thereof;
31) Treatment for human organ tissue transplants and their related Treatment;
32) Occupational diseases, including, but not limited to, disease(s) related to asbestos exposure, and the complications thereof, including asbestosis and mesothelioma related to asbestos exposure;
33) Expenses incurred during a Hospital emergency visit which is not of an Emergency nature;
34) Injury sustained as the result of the Insured Person operating a Motor Vehicle while not properly licensed to do so in the jurisdiction in which the Motor Vehicle Accident takes place;
35) Expenses incurred for which the trip to the Host Country was undertaken to seek Medical Treatment for a condition;
36) Covered Expenses incurred during a trip after Your Physician has limited or restricted travel;
37) Loss or damage (including death or Injury) and any associated cost or expense resulting directly from the discharge, explosion or use of any device, weapon or material employing or involving nuclear fission, nuclear fusion or radioactive force, or chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act regardless of any other cause or event contributing concurrently or in any other sequence thereto;
38) Sex change operations, or for Treatment of sexual dysfunction or sexual inadequacy;
39) Weight reduction programs or the surgical Treatment of obesity, including, but not limited to, wiring of the teeth and all forms of intestinal bypass Surgery;
40) Expenses resulting from Acquired Immune Deficiency Syndrome (AIDS), Aids-Related Complex (ARC) or the Human Immunodeficiency Virus (HIV).
41) Exercise programs, whether or not prescribed or recommended by a Physician;
42) Treatment required as a result of complications or consequences of a Treatment or condition not covered hereunder;
43) Charges for travel accommodations, except as provided for in the Emergency Medical Evacuation/ Repatriation, Return of Mortal Remains, or Emergency Medical Reunion benefits;
44) Diagnosis or Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive materials;
45) Diagnosis or Treatment for acne, moles, skin tags, disease of sebaceous glands, seborrhea, sebaceous cyst, unspecified disease of the sebaceous glands, hypertrophic and atrophic conditions of skin, nevus;

46) Treatment, Services or Supplies that are not administered by or under the supervision of a Physician and products that can be purchased without a Physician's prescription; and/or
47) Treatment of sleep apnea or other sleep disorders;
48) Hernia of any kind;
49) Injury sustained while You are riding as a pilot, student pilot, operator or crew member, in or on, boarding or alighting from, any type of aircraft;
50) Injury sustained while You are riding as a passenger or driver in any aircraft (a) not having a current and valid airworthy certificate; and (b) not piloted by a person who holds a valid and current certificate of competency for piloting such aircraft;
51) Service in the military, naval or air service of any country;
52) Flying in any aircraft being used for, or in connection with, acrobatic or stunt flying, racing or endurance tests;
53) Flying in any rocket-propelled aircraft;
54) Flying in any aircraft being used for, or in connection with, crop dusting or seeding or spraying, firefighting, exploration, pipe or power line inspection, any form of hunting or herding, aerial photography, banner towing or any experimental purpose;
55) Flying in any aircraft which is engaged in any flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted;
56) Being under the influence of alcohol or having taken drugs or narcotics unless prescribed by a legally qualified Physician or Surgeon;
57) Injury occasioned or occurring while You are committing or attempting to commit a felony or to which a contributing cause was the Insured Person being engaged in an illegal occupation;
58) While riding or driving in any kind of competition;
59) Abortion;
60) Loss or damage (including death or Injury) and any associated cost or expense resulting directly from the discharge, explosion or use of any device, weapon or material employing or involving nuclear fission, nuclear fusion or radioactive force, or chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act; and/or
61) Bacterial infections, except pyogenic infection, which shall occur through an Accidental cut or wound.

Definitions

Accident or Accidental means a sudden, unforeseeable, external event independent of Illness or self-inflicted means, which is the direct cause of bodily Injury to an Insured Person.

Administrator means the third arty administrator contracted with the Insurance Company to provide administrative and claims payment services under this Policy.

Alcohol or Drug Abuse means any pattern of pathological use of alcohol or drug that cause impairment in social or occupational functioning, or that produces psychological dependency evidenced by physical tolerance or by physical symptoms when it is

withdrawn.

Benefit Period means the period of coverage issued by the Insurance Company to the Participant, beginning with the Policy Effective Date and ending on the Expiration Date.

Child(ren) means the Participant's natural Child, adopted Child (or Child placed in the Participant's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Participant has legal guardianship (proof will be required). A Child must reside with the Participant in a parent-Child relationship. Note: In the event the Participant shares physical custody of the Child with another parent, the requirement that the Child reside with the Participant will be waived.

Coinsurance means the percentage amount of Covered Expenses, after the Deductible, which is the Participant's responsibility to pay.

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

Company/Insurer means R & Q Quest Insurance Limited for and on behalf of the WellAway Segregated Account and is also referred to as Insurer, Insurance Company, We, Us and Our(s).

Congenital means a physical abnormality or condition that is present at birth, whether inherited or caused by the environment.

Co-payment means a fixed dollar amount that may be applied per office visit for each time medical Services, including consultations and follow ups, are received. Co-payments may also be applicable to some pharmacy benefits and other Eligible Benefits.

Cost Share means your share of the cost for specific Covered Expense under the plan selected including any applicable Deductible, Copayment and/or Coinsurance amounts.

Covered Expense means Eligible Benefit.

Deductible means the dollar amount of Eligible Expenses which must be incurred and paid by the Participant before benefits are payable under this Policy. It applies separately to each Insured Person.

Disablement (as used with respect to medical expenses) means an Illness or an Accidental Injury necessitating Medical Treatment by a Physician.

Drugs/Prescription Drugs means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

Eligible Benefit(s) means benefits payable by the Insurance Company to reimburse expenses which are for Medically Necessary Services, Supplies, care, or Treatment; due to Illness or Injury; prescribed, performed or ordered by a Physician; Reasonable and Customary Charges; incurred while an Insured Person under this Policy and which do not exceed the Maximum Benefit.

Eligible Expenses means the Reasonable and Customary Charges for Services or Supplies which are incurred by the Insured Person for the Medically Necessary Treatment of an Injury or Illness. Eligible Expenses must be incurred while the Policy is in force.

Emergency means an Illness or Injury for which the Insured Person seeks immediate Medical Treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that, without immediate medical care, a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause:

- His life or health would be in serious jeopardy, or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn Child;
- His bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

Emergency Medical Evacuation/Repatriation means: a) medical condition that warrants immediate transportation from the place

where the Insured Person is located (due to inadequate medical facilities) to the nearest adequate medical facility where Medical Treatment can be obtained; or b) after being treated at a local medical facility, the medical condition warrants transportation with a qualified medical attendant to the Insured Person's Home Country to obtain further Medical Treatment or to recover; or c) both a) and b) above.

Expatriate means (1) a person working or living outside their country of citizenship; (2) a person working outside their country of citizenship and outside the employer's country of domicile; or (3) non-U.S. citizens working in the United States.

Experimental/Investigational means a drug, device or medical care or Treatment that is considered experimental/ investigational if:

- The drug or device cannot be lawfully marketed without approval of the Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or has FDA approval, but does not have evidence of effectiveness for the proposed use documented in peer reviewed articles in medical journals published in the United States.

- The informed consent document utilized with the drug, device, medical care or Treatment states or indicates that the drug, device, medical care or Treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law.

- The drug, device, medical care or Treatment or the patient informed consent document utilized with the drug, device or medical care or Treatment was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal or state law requires such review and approval.

- Reliable evidence show that the drug, device or medical care or Treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

- Reliable evidence show that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

For purposes of this definition, "reliable evidence" means published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or Treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or Treatment.

Administrator will make the determination if the drug, device or medical care is Experimental/Investigational based on the above criteria. The Company will make the final determination as to whether a Service or Supply is Experimental/Investigational.

Expiration Date means date this Policy ends as set forth in the Certificate of Coverage.

Family Member means a spouse, father, mother, brother, sister, or child of the Insured Person or domestic partner.

Full-Time Educational or Research Activities means the Insured Person is enrolled and participating in an educational, vocational, cultural exchange, or training program.

He, His and Him includes "she", "her" and "hers."

Highway means every public way, road, street, thoroughfare and place, including bridges, viaducts and other structures, open, used or intended for use of the general public for vehicles or vehicular traffic as a matter of right.

Home Country means the country where an Insured Person has his or her true, fixed and permanent home and principal establishment.

Hospital means an institution licensed, accredited or certified by the applicable state that:

1) Operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons;

2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;

3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call;

4) Has a staff of one or more licensed Physicians available at all times;

5) Provides organized facilities for diagnosis, treatment and surgery, either

    a. on its premises; or

    b. in facilities available to it, on a pre-arranged basis;

6) Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and

7) Is not a place for drug addicts, alcoholics or the aged.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. Hospital does not include a place, special ward, floor or other accommodation used for custodial or educational care; rest; the aged; a nursing home or an institution mainly rendering Treatment or Services for Mental Illness or Substance Abuse, except as specifically stated.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

Host Country means any country other than the country where an Insured Person has his or her true, fixed and permanent home and principal establishment.

Identification Card (ID card) means the cards we issue to Participants. The cards are our property and are not transferable to another person. Possession of such card in no way verifies that an individual is eligible for, or covered under, this Policy.

Illness means a sickness, disorder, Illness, pathology, abnormality, malady, morbidity, affliction, disability, defect, handicap, deformity, birth defect, Congenital defect, symptomatology, syndrome, malaise, infection, infirmity, ailment, disease of any kind, or any other medical, physical or health condition, provided, however, that Illness does not include learning disabilities, or attitudinal or disciplinary problems. All Illnesses that exist simultaneously or which arise subsequent to a prior Illness and which directly or indirectly relate to or result or arise from the same or related causes or as a consequence thereof or from one another are considered to be one Illness. Further, if a subsequent Illness results or arises from causes or consequences that are the same as or related to the causes or consequences of a prior Illness, the subsequent Illness will be deemed to be a continuation of the prior Illness and not a separate Illness. Any complication or any condition arising out of an Illness for which the Insured Person is being treated or has received Treatment will be considered as part of the original Illness.

Injury means bodily harm resulting, directly and independently of disease or bodily infirmity, from an Accident. All injuries to the same person sustained in one Accident, including all related conditions and recurring symptoms of injuries will be considered one Injury.

In-Network Provider means any health care Provider who, at the time covered Services are rendered to you, is under contract with us to participate as an In-Network Provider for Services or as a Preferred Provider included in the panel of Providers designated by us as Preferred Providers for your specific plan. For payment purposes under this Policy only, the term In-Network Provider also refers, when applicable, to any health care Provider located outside the state of domicile or residence who or which, at the time Services are rendered to you, participates as an In-Network Provider for Insurer or its third party administrator.

Loss, for the Accidental Death and Dismemberment benefit, means quadriplegia, paraplegia, hemiplegia, and uniplegia, the complete and irreversible paralysis of such limbs; with regard to hands and feet, actual severance through and above the wrist or ankle joints; with regard to eyes, entire irrecoverable loss of sight; and, with regard to thumb and index finger, actual severance through or above the joint that meets the finger at the palm. Loss in reference to other coverages means Injury or damage sustained by an Insured Person as a consequence of the happening of one or more of the Accidents against which the Insurance Company has undertaken to indemnify the Participant.

Inpatient means the Insured Person is confined in an institution and is charged for room and board.

Intensive Care means a cardiac care unit or other unit or area of a Hospital which meets the required standards of the Joint Commission on Accreditation of Hospitals for special care units.

Insurance means the coverage that is provided under this Policy.

Insurer means R&Q Quest Insurance Limited for and on behalf of the WellAway Segregated Account.

Insured Person means the Participant or His Dependents enrolled for and entitled to coverage under this Policy and for whom the required Premium has been paid.

Maximum Benefit means the largest total amount of Eligible Expenses that the Company will pay for the Insured Person as indicated in the Summary of Benefits.

Medically Necessary means a Treatment, drug, device, Service, Procedure or Supply that is:

1) Required, necessary and appropriate for the diagnosis or Treatment of an Illness or Injury; and

2) Prescribed or ordered by a physician or furnished by a hospital; and

3) Performed in the least costly setting required by the condition; and

4) Consistent with the medical and surgical practices prevailing in the area for Treatment of the condition at the time rendered;

5) Not excessive in scope, duration, or intensity to provide safe and adequate, and appropriate Treatment. When specifically applied to Hospital confinement, it means that the diagnosis or Treatment of symptoms or a condition cannot be safely provided on an Outpatient basis.

Note

1. The purchasing or renting air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them, and general exercise equipment are not considered Medically Necessary. A Service or Supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or Treatment alternative could have been used. We may consider the cost of the alternative to be the Eligible Expense.

2. The fact that any particular Physician may prescribe, order, recommend, or approve a Service, Supply, or level of care does not, of itself, make such Treatment Medically Necessary or make the charge a Covered Expense under this Policy.

3. A Treatment, drug, device, Procedure, Supply or Service shall not be considered as Medically Necessary if it:

    - Is Experimental/Investigational or for research purposes;

    - Is provided for education purposes or the convenience of the Insured Person or the Insured Person's Family Members, Physician, Hospital or any other Service Provider;

    - Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or Treatment and where ongoing Treatment is merely for maintenance or preventive care;

    - Could have been omitted without adversely affecting the person's condition or the quality of medical care;

    - Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration; or

    - Can be safely provided to the patient on a less cost effective basis such as Outpatient, by a different medical professional, or pursuant to a more conservative form of Treatment.

Medical Treatment means examination, Treatment, and/ or consultation by a Physician for a condition which first manifested itself,

worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or Treatment.

Mental Illness and Mental and Nervous Disorder means any mental, nervous, or emotional Illness which generally denotes an Illness of the brain with predominant behavioral symptoms; or an Illness of the mind or personality, evidenced by abnormal behavior; or an Illness or disorder of conduct evidenced by socially deviant behavior. Mental or Nervous Disorders include, without limitation: psychosis; depression; schizophrenia; bipolar affective disorder; any disease or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of the International Classification of Diseases as published by the U.S. Department of Health and Human Services; and those psychiatric and other Mental Illnesses listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders published by the American Psychiatric Association. Mental Illness and Mental and Nervous Disorder does not mean or include learning disabilities, attitudinal disorders or disciplinary problems.

Motor Vehicle means any self-propelled vehicle and any such vehicle in combination with any trailing units, used or physically capable of being used upon any public Highway for the transportation of persons or property.

Motor Vehicle Accident means the unintended collision of one Motor Vehicle with another Motor Vehicle, stationary object, and/or person, resulting in Injuries, death, and/or Loss of property.

Mountaineering means the sport, hobby or profession of walking, hiking, and climbing up mountains either: 1) utilizing harnesses, ropes, crampons or ice axes; or 2) ascending 4,500 meters or above.

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

Occupational Disease means an Illness or Injury resulting from or in the course of any employment for wage or profit by the Insured Person. Occupational Disease is not a contagious disease resulting from exposure to fellow employees or from a hazard to which the workman would have been equally exposed outside of his employment. An Occupational Disease is also not an ordinary disease of life to which the general public is equally exposed, unless such disease follows as a complication and a natural incident of an Occupational Disease or unless there is a constant exposure peculiar to the occupation itself that makes such disease a hazard inherent in such occupation.

Outpatient means an Insured Person who receives care in a Hospital or another institution, including; ambulatory surgical center; or Physician's office, for an Illness or Injury, but who is not confined and is not charged for room and board.

Outpatient Surgical Facility means a surgical or medical center which has (1) permanent facilities for surgery; (2) organized medical staff of Physicians and registered graduate Registered Nurses; (3) is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under law.

Out-of-Network Provider means a Provider who, at the time Services are rendered to you, does not have a contract with us to participate as an In-Network Provider.

Out-of-Pocket means your expenses for Services that are not reimbursed by us. Out-of-Pocket expenses include, but is not limited to, Deductibles, Coinsurance and Copayments for Eligible Benefits plus all costs for Services that are not covered.

Out-of-Pocket Maximum means the maximum dollar amount the Participant is responsible to pay during a Benefit Period per Injury or Illness. After the Participant has reached the Out-of-Pocket Maximum, the Policy pays 100% of Eligible Expenses for the remainder of the Injury or Illness. The Out-of-Pocket Maximum is met by accumulated Deductible, Copayments and Coinsurance. Penalties and amounts above the Reasonable and Customary Charges do not count toward the Out-of- Pocket Maximum. The Out-of-Pocket Maximum is shown on the Summary of Benefits.

Parachuting means an activity involving the breaking of a free fall from an air using a parachute.

Permanent Resident means the country where a Participant has his or her true, fixed and permanent home and principal establishment, and to which he or she has the intention of returning.

Physician or Legally Qualified Physician or Surgeon means a person who is a qualified practitioner of medicine. As such, he or she must be acting within the scope of his/her license under the laws in the jurisdiction in which he or she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Participant or a Participant's Family Member of Relative.

Policy means this document, the application of the Participant and any endorsements, riders or amendments that will attach during the Benefit Period.

Policy Effective Date means the date that this Policy first takes effect, without regard to renewals thereafter.

Participant means a person eligible for coverage as identified in the application, for whom proper Premium payment has been made when due, and who is therefore a Participant under this Policy.

Pre-Existing Condition means any medical condition, sickness, Injury, Illness, disease, Mental Illness or Mental Nervous Disorder, regardless of the cause including any Congenital, chronic, subsequent, or recurring complications or consequences related thereto or resulting therefrom that with reasonable medical certainty existed at the time of application, whether or not previously manifested, symptomatic, known, diagnosed, treated or disclosed. This specifically includes, but is not limited to, any medical condition, sickness, Injury, Illness, disease, Mental Illness or Mental Nervous Disorder, for which medical advice, diagnosis, care or treatment was recommended or received or for which a reasonably prudent person would have sought treatment during the six (6) month period immediately preceding the Policy Effective Date and any medically recognized complication or recurrence of a medication condition including, but not limited to, follow-up exams, investigations, medications, change of type of medication or change of dosage of medication, and in general all medical and laboratory exams, x-rays, etc. related to such condition. Pre-Existing Conditions are not covered under this Policy.

Preferred Provider means a Provider of health care or a group of Providers of health care that has been established and so designated by us as a Preferred Provider under this Policy.

Premium(s) means the consideration owed by the Participant to the Insurer in order to secure benefits for its Insured Persons under this Policy.

Procedure means a practice, a series of steps, or Treatment to follow after a given Diagnosis is obtained.

Reasonable and Customary Charges means the most common charge for similar professional Services, drugs, Procedures, devices, Supplies or Treatment within the area in which the charge is incurred. The most common charge means the lesser of:

- The actual amount charged by the Service Provider;
- The negotiated rate; or
- The charge which would have been made by the Service Provider for a comparable Service or Supply made by other Service Providers in the same Geographic Area, as reasonably determined by Us for the same Service or Supply.

Registered Nurse means a licensed registered professional Registered Nurse (R.N.).

Rehabilitation Facility means a non-residential facility that provides therapy and training rehabilitation services at a single location in a coordinated fashion, by or under the supervision of a physician pursuant to the law of the jurisdiction in which treatment is provided. The center may offer physical therapy. The facility may be either of the following:

1) A Hospital or a special unit of a Hospital designated as a Rehabilitation Facility; or

2) A free standing facility.

Relative means Spouse, parent, sibling, Child, grandparent, grandchild, step-parent, step-child, step- sibling, in-laws (parent, son, daughter, brother and sister), aunt, uncle, niece, nephew, legal guardian, ward, or cousin of the Participant.

Service(s) means evaluations, Treatments, therapies, devices, Procedures, techniques, equipment, Supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds and other services rendered or supplied, by or at the direction of, a licensed Physician or Service Provider.

Service Provider/Provider means a Hospital, ambulatory surgical center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, birthing center, Physician, Dentist, chiropractor, licensed medical practitioner, Registered Nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility

that the Company approves.

Sound Natural Tooth means a tooth that is whole or properly restored; is without impairment, periodontal or other conditions; is not more susceptible to Injury than a virgin tooth, and is not in need of the Treatment provided for any reason other than Accidental Injury. A tooth previously restored with a crown, inlay, or porcelain restoration, or treated by endodontics is not a Sound Natural Tooth.

Spouse means lawful spouse, if not legally separated or divorced, or Domestic Partner.

Substance Abuse means alcohol, drug or chemical abuse, overuse or dependency.

Supply means items deemed necessary for the Treatment of an Illness or Injury.

Surgery or Surgical Procedure means an invasive or diagnostic Procedure; or the Treatment of Illness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.
Terrorism or Terrorist Activity means an act, or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorism can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of Terrorism can either be acting alone, or on behalf of, or in connection with any organization(s) or governments(s).

Third Party means a person or entity other than the Participant, Dependent(s), the Company, Family Member, Relative or employees of an Insured Person.

Treatment means a specific in-office or Hospital physical examination of or care rendered to You, consultation, diagnostic Procedures and Services, Surgery, medical Services and Supplies including medication prescribed or provided by a Service Provider.

Waiting Period means the period of time beginning with the Policy Effective Date, during which limited or no benefits are available for particular Services.

We, Our, Us means R&Q Quest Insurance Limited for and on behalf of the WellAway Segregated Account.

You, Your, Yours, He or She means the Participant and the Participant's Spouse or Dependents who meet the eligibility requirements of this Policy and whose insurance under this Policy is in force.

Claims Administrative Procedures

All claims are subject to Reasonable and Customary Charges as determined by Insurer and are processed in the order in which they are received by Insurer. In order for claims payment to be made, claims must be submitted in a form acceptable to Insurer. Claim forms may be obtained from the member portal at www.wellaway.com.

Procedures for Payment

For all Covered Expenses, we may pay either the Hospital, Provider or Insured Person. For most Hospital confinements we will provide direct payment to the Hospital. In such cases, the Insured Person will continue to be responsible for all non-covered expenses including, but not limited to, Cost Share amounts and any amounts in excess of Reasonable and Customary Charges. Upon admission to the Hospital, the Insured Person should:

1. Present the Insured Person's Identification Card; and

2. Provide any additional information required by the Hospital in order to be admitted.

The Hospital will inform the Administrator, who in turn, will verify Eligibility and the benefits provided under this Policy. The Hospital may submit a claim and will be paid directly by us. The Insured Person will be billed only for expenses that are not covered by this Policy. If the Hospital does not arrange for direct payment, the Insured Person will be responsible to pay the Hospital and submit a claim for reimbursement.

This Policy applies site of service payment differential for professional services based on the setting in which the services were provided, unless provider, or state or federal requirements indicate otherwise.

- The applicable fee schedule or contracted/negotiated rate in line with the state provider contract, which may include a site of service differential.
- The applicable out-of-network reimbursement rate for nonparticipating providers.
- Some services, by nature of their description, are performed only in certain settings and have only one maximum allowable fee per code.

Notice of Timely Filing

All claims must be received by the Administrator no later than sixty (60) days from the date of Service. Claims received after this date will be denied.

Claims submitted by the Provider in the US

Insured Person must provide all health care Providers with a copy of his/her Identification Card. The claims must be submitted to

Insurer directly by the Provider within sixty (60) days from the date of Service. Medical claims submitted by Providers in the United States should be in CMS 1500 formats, or UB04 CMS formats. No benefits will be paid for claims exceeding this time period. If the Insured Person has already paid the Provider, the Insured Person must submit the claim pursuant to the guidelines set forth below. Insurer will reimburse the Insured Person in accordance with the terms of the Provider contract, if one exists.

Claims submitted by the Insured Person

The Insured Person must submit complete claims directly to the Administrator within sixty (60) days from the date of Service. Copies of claims are accepted as long as the integrity of the document is not altered. However, we reserve the right to request original documents at our discretion. If the complete claim is not received within sixty (60) days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

1) it can be shown that it was not possible within reason to submit notice within the sixty (60) day period; and

2) it is further shown that notice was given as soon as possible.

The claim form is available for our member portal at www.wellaway.com or you may request the claim form by calling a ConciergeCare Counselor at +1 888 959 2296 or e-mail: avistudents@payerfusion.com. All claims must be accompanied with the following:

- Claimant's name.
- Physician's specialty.
- Detailed description of Service rendered (office visits, Surgery, etc.).
- Original itemized invoices with fees on Physician/ Hospital letterhead. Invoice must include patient's full name, date of birth, Diagnosis (type of Illness), date of the visit, Treatment type, Physician's charges and acceptable proof of payment (credit card receipt).
- Prescription medications must clearly provide the name of the patient, the price of the Drug, and prescription quantity. Copy of the Physician's script is required.
- In the case of hospitalization, you must attach the Hospital medical notes or reports, and our Pre- Authorization provided to you. Please ensure that your invoice details the cost of private or semi-private room.
- In the case of death, a certified copy of the death certificate.

Claims may be submitted via e-mail to avistudents@payerfusion.com, courier, or by postal service. Mail your completed claim documents to:

Attention: PayerFusion Holdings, LLC
5200 Blue Lagoon Drive, Suite 100
Miami FL 33126

E-mail: avistudents@payerfusion.com

Note: Insurer will reimburse the Insured Person in accordance with the terms and conditions of the Policy. We encourage the Insured Person to keep copies of the invoices for their records.

Payment of Benefits

Upon the Insurer's receipt of proper and acceptable written proof of expenses incurred, the Administrator will:

A) Pay covered benefits under this Policy; or

B) Notify the Insured Person (or claimant on behalf of the Insured Person), in writing, the reasons for non- payment of the claim; or

C) Notify the Insured Person (or claimant on behalf of the Insured Person), in writing, that additional information is necessary for the review and/or payment of the claim within the terms of this Policy.

Claims Payment

Whenever possible, the Administrator will settle the expenses directly with the Providers for Services rendered. When not possible, the Administrator will reimburse the Participant in accordance with the terms and conditions of this Policy.

Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of this Policy. If the Participant dies before all payments due have been made, the amount still payable will be paid to His beneficiary as described in the Designation and Change of Beneficiary provision of this Policy. If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, we may pay up to $2,500 to a Relative by blood or marriage whom We believe is equitably entitled. This good faith payment satisfies Our legal duty to the extent of that payment. Any other accrued benefits which are unpaid at a Participant's death may, at Our option, be paid either to His beneficiary or to His estate. All other benefits, unless specifically stated otherwise, will be paid to the Participant.

Designation or Change of Beneficiary

Each Participant may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order:

1) Beneficiaries designated in writing by the Participant for the Policy on file with the Participant, if any, otherwise;

2) Beneficiaries as designated in writing for any group life insurance or its renewals in force for the Participant, if any, otherwise;

3) In equal shares to the members of the first surviving class of those that follow, if any:

    a) a Participant's lawful Spouse, if not legally separated or divorced, or Domestic Partner; or

    b) a Participant's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Participant has or had legal guardianship (proof will be required); or

    c) a Participant's parents, whether natural, step or adoptive; or

    d) a Participant's sisters or brothers, otherwise.

4) The estate of the Participant.

A Participant may change His beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Company. When a request for designation or change is received by the Company, it will take effect on the date of its execution, whether or not the Participant is living on the date it is received by the Company. Any interest created by the request will be subject to any payment made or action taken before its receipt.

A Dependent's beneficiary is the Participant. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Participant's estate.

Physical Examination and Autopsy

We have the right to have a Physician of Our choice examine the Participant as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death. We will pay the cost of the examination or autopsy.

Recovery of Overpayment

If benefits are overpaid, or paid in error, we have the right to recover the amount overpaid or paid in error by any of the following methods:

1) A request for lump sum payment of the amount overpaid or paid in error; or

2) Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error.

Recovery of Benefits

We reserve the right to recover from a Participant any benefits We have paid to Him for Injuries:

1) Received in a covered Accident; and

2) Which are covered under:

    a) workers' compensation or similar statutory remedies available under law; or

    b) Any employer's liability Insurance.

It will be assumed that the Participant is in receipt of such benefits unless He gives us proof such benefits have been denied to him.

Right of Reimbursement / Subrogation

If a Participant recovers expenses for Illness or Injury that occurred due to the negligence of a Third Party, We have the right to reimbursement for all benefits We paid from any and all damages collected from the negligent Third Party for those same expenses whether by action at law, settlement, or compromise, by the Participant, the Participant's parents if the Participant is a minor, or the Participant's legal representative as a result of that Illness or Injury. We are assigned the right to recover from the negligent Third Party, or his or her insurer, to the extent of the benefits We paid for that Illness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the Third Party admits liability.

Legal Actions

No legal action may be brought to recover on the Policy within sixty (60) days after a completed claim has been furnished. No legal action may be brought after one year from the time a completed claim is required to be furnished.

General Provisions

Entire Contract; Changes

The Policy, the application of the Participant, endorsements, riders, and the with the Participant and attached papers constitute the entire contract between the parties. If an application of a Participant is required, the application of any Participant, at Our option, may also be made a part of this contract.

No change in the Policy will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached

to the Policy. No agent may change the Policy or waive any of its provisions. Benefits and Premiums in this Policy are denominated in US Dollars.

Patient Protection and Affordable Care Act

The Insurance provided under this Policy is not subject to, and does not provide certain insurance benefits required by the United States Patient Protection and Affordable Care Act (‘PPACA’). The Insurance provided by this Policy are stated in the Policy documents and do not include additional benefits required be PPACA. The PPACA requires certain US residents and citizens to obtain PPACA compliant insurance coverage. In certain circumstances penalties may be imposed on US residents and citizens who do not maintain PPACA compliant insurance coverage. A Participant should consult an attorney, insurance agent or tax professional to determine if the PPACA’s requirements are applicable to Him.

Policy Termination

Insurer reserves the right to cancel your Policy effective as of 12:01 a.m. Eastern Standard Time (EST) on such date that an Insured Person:

A) Is no longer eligible as defined by this Policy.

B) Failed to observe the terms and conditions of this Policy, or failed to act with utmost good faith.

C) Failed to pay the required Premium at the end of the grace period. Insurer may, at its sole discretion, reinstate the Policy if the Premium is subsequently paid (in such event, Insurer may defer or cancel payment of all or any claims for expenditures Incurred during the period the Premium remains unpaid).

D) Requested, in writing, to terminate coverage on the last day of the period for which Premium has been paid.

E) Acts in a manner that results in added costs to the Insurer.

F) The Insured Person must exercise reasonable care to prevent an Accident, Injury, Loss or damage and, at all times, act as if uninsured.

G) This plan may be refunded for 100% of premium. Processing and acceptance of a refund is contingent upon written notification to the Insurer. If a refund is requested AFTER the inception date of the Policy, the unused portion of the Policy will be refunded on a prorated basis PROVIDED NO CLAIM(S) has been submitted to the Insurer. If there is a claim in process or has been previously paid then the Policy will be deemed as 100% non-refundable. Insured Person must provide proof of return date to Home Country. The calculation of any refund is based on the number of days remaining and is ONLY eligible in the event there are no claims on file during the entire period of insurance.

H) Committed an act of Fraud with respect to this Policy. Fraud means deception by a person with the intent to wrongly benefit him/her. It includes any act that is defined as fraud under federal or state laws, and includes, but is not limited to:

(i) Using another person’s name as your own;

(ii) Using an ID Card that does not belong to you; (iii) Giving your ID card to someone else;

(iv) Misuse of Services;

(v) Billing for Services that were not provided;

(vi) Giving false information on your records: This includes records that relate to your eligibility;

(vii) Giving statements on the application which are found to be misrepresentations or are incomplete or incorrect;

(viii) Knowingly claiming benefits for any purpose other than as provided for under this Policy;

(ix) Agreeing to any attempt by a Third Party action or omission to obtain an unreasonable pecuniary advantage to our detriment; or

(x) Purchasing this Policy for the purpose of cancelling it after a planned medical Service has been rendered.

Insurer further reserves the right to cancel your Policy in the event the plan ceases to operate. Insurer will inform the Participant at least thirty (30) business days in advance and will inform the Participant of similar plans and benefit options available where the Participant can renew his/her Policy.

Note: In the event an Insured Person's coverage terminates for any reason other than fraud, we would only be liable for the Treatment covered under the terms of the Policy that took place before the effective date of termination of the Insured Person's coverage.

Fraudulent/Unfounded Claims

If any claims presented under this Policy are in any respect fraudulent or unfounded, or if any fraudulent means or devices are used by the Insured Person or anyone acting on the Insured Person's behalf, such as misrepresentation on the application, omissions of information or any attempts, through deceit, to obtain benefits for any person that otherwise would not be provided or payable, we will deny all benefits paid and/or payable in relation to that claim and all Premiums previously paid shall be forfeited and, if appropriate, recoverable. We will terminate the Policy as of the Policy Effective Date.

Clerical Error:
Clerical error in keeping any records pertaining to the coverage, whether by the Participant, its Administrator or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

Assignment:
No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

Insolvency:
The insolvency, bankruptcy, financial impairment, receivership, voluntary of arrangement with creditors, or dissolution of the Participant will not impose upon the Company any liability other than the liability defined in the Policy. The insolvency of the Participant will not make the Company liable to the creditors of the Participant, including Participants under the Policy. Unless specified, this Policy does not cover anything caused directly or indirectly through bankruptcy/liquidation of any tour operator, travel agent, and transportation company or accommodation supplier.

Waiver:
Failure of the Company to strictly enforce its rights under the Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

About the Administrator

The Insurer has selected PayerFusion Holdings, LLC as the Administrator of WellAway Limited. Administrator has provided accident and sickness third party administrative services to insurance to corporations, international travelers, expatriates, students, overseas visitors, immigrants and global citizens. With expertise and efficiency, it has served clients worldwide. Assistance Services are also provided by PayerFusion Holdings, LLC.

Information We Disclose

The non-public personal information that we collect about the Participant includes, but is not limited to:

a. Information contained in applications or other forms that the Participant submits to us, such as name, address and date of birth.

b. Information about the Participant's transactions with our affiliates or other third-parties, such as balances and payment history.

We disclose the information that we have when it is necessary to provide our products and services. We may also disclose information when the law requires or permits us to do so.

Confidentiality and Security

Only our employees and others who need the information to service the Participant or Participant's account have access to the information. We have measures in place to secure our paper files and computer systems.

Right to Access or Correct Your Personal Information

Participants have a right to request access to or correction of their personal information that is in our possession.

Claims Appeal Procedures

Insurer will provide a written explanation of the reason if it denies, in whole or in part, a claim for benefits under this Policy. If there is any question about the settlement or denial of a claim, the Insured Person will have the right to request a full and fair review of that claim.

The process is as follows:

- Within sixty (60) days of receiving a claim denial, the Insured Person must write to the Insurer or Plan Administrator stating the reasons for the appeal and any additional information to support the claim.
- The Insured Person must include in the appeal the following information: the Policy number, the Insured Person's name for whom the claim was made, the Provider, the amount of the claim, the date the claim was made, and the date it was denied.
- The Plan Administrator will set up the appeal for an independent review board to review the case and provide the recommendation to the Insurer.
- Within an additional sixty (60) days of receiving the written appeal, the Insurer or Plan Administrator will notify the Insured Person by mail of the final decision and the specific reason for the decision. If a more extensive review is required, a final decision will be made within one hundred twenty (120) days from the date the appeal is received in writing by Insurer or the Plan Administrator.

- You must send copies of all correspondence regarding claim appeals to our Plan Administrator.

To File a Complaint

Any initial inquiry or complaint should be addressed to the Administrator. If the Participant is not satisfied with the manner in which an inquiry or complaint has been managed by the Administrator, the Participant may request in writing to the Complaints Department at WellAway Limited to review the case without prejudice to the Participant's rights in law. We aim to keep our customers satisfied; however, we understand that there are instances whereby we may not be able to meet your expectations. Should you wish to file a formal complaint, please contact us by post, telephone or e-mail.

WellAway Ltd.
Cannon's Ct., 22 Victoria St. PO Box HM1179
Hamilton, HM EX, Bermuda

Phone: +1.888.959.2296
Email: Conciergecare@wellaway.com
Website: www.wellaway.com

Our Contact Numbers

For a ConciergeCare Counselor, to request Pre-Authorization, or to check on the status of a claim, we can be reached at the following numbers:

United States toll-free and via Skype from anywhere in the world: +1.888.959.2296 or Outside the USA (call collect): +1.786.558.2033 or E-mail: avistudents@payerfusion.com