SCHEDULE

The data entered below is subject to the applicable provisions of the Policy in accordance with the Benefits/Coverages provided.

Policy Number:	GLM N14285969
Effective Date:	See Participant ID Card
Termination Date	See Participant ID Card
Name of Insured:	See Participant ID Card
Address:	See Participant ID Card
City, State and Zip Code:	, ,

INBOUND BENEFIT SCHEDULE

Medical Expense Benefit

Total Maximum for all Medical Expense Benefits:	$250,000
Deductible:	$250
Deductible for Emergency room visits As a result of a Covered Sickness*:	$300
Co-insurance Rate:	80% to Policy Max
Incurral Period:	30 days from the date of covered Injury or commencement of Sickness
Maximum Benefit Period:	The earlier of 52 weeks or the date the Insured returns to his or her Home Country
Maximum for Room & Board Charges:	$750 per day
Maximum for ICU Room & Board Charges:	$1,000 per day
Maximum for injuries sustained as a result of a Covered motor vehicle accident:	$10,000

*The Emergency Room Deductible will be waived if the Insured Person is admitted to the Hospital as an inpatient.

Maximum for Pre-existing Conditions:	No Coverage
Maximum for Mental and Nervous Disorders:	
Inpatient Treatment:	Up to the Medical Expense Benefit Maximum
Inpatient Maximum:	30 days
Outpatient Treatment:	Up to the Medical Expense Benefit Maximum
Co-insurance Rate:	100%
Maximum for Dental Injury Only:	Up to the Medical Expense Benefit Maximum

Maximum for Therapeutic Termination of pregnancy:	$500
Maximum for Chiropractic Services and Therapeutic Services:	$500
Maximum Number of Visits:	$50 per visit
Co-insurance	100%
Prescription Drugs Inpatient and Outpatient	100% of Covered Expenses

Emergency Medical Evacuation Benefit

Benefit Maximum:	$100,000

Repatriation of Remains Benefit

Benefit Maximum:	$50,000

Personal Property and Financial Instrument Reimbursement Benefit

Deductible per occurrence:	$50
Benefit Maximum:	$250 Max per item
Benefit Maximum for any One or Set of Articles:	$100
Financial Instrument Benefit Maximum:	$250 Max per item
Benefit Maximum for Cash:	$500

Trip Delay Benefit

Benefit Payable:	$500 ($100/day)

Premium Schedule

Premium Due Date: As shown on the Confirmation Statement
Amount: As shown on the Confirmation Statement

CHUBB®

Underwritten by:
ACE American Insurance Company
436 Walnut Street
Philadelphia, PA 19106

Individual Student Travel Policy

This is a legal contract between ACE American Insurance Company and the Insured. This Policy is made up of the Benefit Schedule, Application and any attached Riders or Endorsements. It is issued in consideration of the payment of the required premium. We will pay benefits according to the terms and conditions of coverage described in this Policy.

THIS POLICY PROVIDES LIMITED BENEFITS FOR TRAVEL RELATED INSURANCE ONLY.
THERE IS NO COVERAGE FOR SICKNESS EXCEPT AS SPECIFIED.
THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.
PLEASE READTHIS POLICY CAREFULLY.

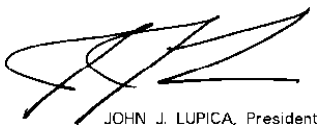
THIS IS A NON-RENEWABLE POLICY.
This Policy is issued for a single term as stated in the Schedule.

TEN DAY RIGHT TO EXAMINE POLICY

The Insured has the right to return this Policy to Us within 10 days of receipt, and to have the premium refunded if, after examination, the Insured is not satisfied with this Policy for any reason.

This Policy is governed by the laws of the state in which it is delivered.

Signed for ACE AMERICAN INSURANCE COMPANY at Philadelphia, Pennsylvania.



JOHN J. LUPICA, President

REBECCA L. COLLINS, Secretary

TABLE OF CONTENTS

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Benefit Schedule.

"Covered Accident" means an accident that occurs while coverage is in force for an Insured and results directly and independently of all other causes in a loss or Injury covered by the Policy for which benefits are payable.

"Covered Expenses" means expenses actually incurred by or on behalf of an Insured for treatment, services and supplies covered by this Policy. Coverage under this Policy must remain continuously in force from the date of the Covered Accident or Sickness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

"Covered Loss" or "Covered Losses" means an accidental death, dismemberment or other Injury covered under this Policy.

"Deductible" means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Insured on a per Covered Accident or Sickness basis before Medical Expense Benefits and any other Additional Benefits paid on an expense incurred basis, are payable under this Policy.

"Doctor" means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to an Insured that is appropriate for the conditions and locality. It will not include an Insured or a member of the Insured's Immediate Family Member or household.

"Home Country" means a country from which the Insured holds a passport. If the Insured holds passports from more than one country, his or her Home Country will be that country which the Insured has declared to Us in writing as his or her Home Country.

"Hospital" means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2) provides 24-hour nursing service by Registered Nurses on duty or call; 3) has a staff of one or more licensed Doctors available at all times; 4) provides organized facilities for diagnosis, treatment and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5) 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 6) is not a place solely for drug addicts, alcoholics, or the aged or any separate ward of the Hospital.

"Immediate Family Member" means a person who is related to the Insured in any of following ways: spouse; parent (includes stepparent); child age 18 or older (includes legally adopted and step child); brother or sister (includes stepbrother or stepsister); parent-in-law; son- or daughter–in–law; and brother- or sister-in-law.

"Injury" means accidental bodily harm sustained by an Insured that results directly and independently from all other causes from a Covered Accident. The Injury must be caused solely

through external, violent and accidental means. All injuries sustained by one person in any one Covered Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

"Insured" means the person who applies for coverage and pays the required premium.

"Medical Emergency" means a condition caused by an Injury or Sickness that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

"Medically Necessary" means a treatment, service or supply that is: 1) required to treat an Injury or Sickness; prescribed or ordered by a Doctor or furnished by a Hospital; 2) performed in the least costly setting required by the Insured's condition; and 3) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. Purchasing or renting 1) air conditioners; 2) air purifiers; 3) motorized transportation equipment; 4) escalators or elevators in private homes; 5) eye glass frames or lenses; 6) hearing aids; 7) swimming pools or supplies for them; and 8) general exercise equipment are not 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 Covered Expense.

"Pre-existing Condition" means – an illness, disease or other condition of the Insured, that in the 12-month period before the Insured's coverage became effective under this Policy:

1. first manifested itself, worsened, became acute or exhibited symptoms that would have caused a person to seek diagnosis, care or treatment; or
2. required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or
3. was treated by a Doctor or treatment had been recommended by a Doctor.

"Sickness" means an illness, disease or condition of the Insured that causes a loss for which an Insured incurs medical expenses while covered under this Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

"Travel Companion" means a person traveling with the Insured who shares the Insured's accommodations.

"Trip" means travel by air, land, or sea from the Insured's Home Country or place of residence. It includes direct flight connections to join and depart an arranged Trip, provided such flights are scheduled to commence while this Policy is in force.

"Usual and Customary Charge" means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

"We", "Our", "Us" means the insurance company underwriting this insurance

EFFECTIVE DATE OF INSURANCE

Insurance becomes effective on the latest of:
1. the Effective Date shown in the Schedule;
2. the date We receive the completed Application;
3. the date the required premium is paid;
4. the date of the actual scheduled Trip, provided We receive the completed Application and the required premium payment; and
5 the date and time the Insured starts his or her Trip.

TERMINATION DATE OF INSURANCE

Insurance will end on the earliest of:
1. the Termination Date shown in the Schedule;
2. the date the period ends for which premium is paid;
3. the date the Insured returns to his or her Home Country or country of permanent residence (unless the Home Country Benefit is purchased);
4. the date the Trip is completed.

Termination of this Policy will not affect a claim for loss which occurs while this Policy is in effect.

EXTENSION OF BENEFITS

We will extend benefits under this Policy for 30 days after an Insured's coverage would otherwise end, if on that date he or she is:
1. Hospital confined for an Injury or Sickness covered by this Policy; and
2. under a Doctor's care.

Any benefits payable under this provision will not exceed the benefit maximums shown in the Benefit Schedule.

PREMIUMS PROVISIONS

Payment of Premium: The first Premium is due on the Policy Effective Date. If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Grace Period: After the first Premium is paid, We will allow a Grace Period of 31 days for the payment of each subsequent Premium amount due. During the Grace Period this Policy will stay in force.

Unpaid Premium: Upon the payment of a claim under this Policy, any Premium due and unpaid will be deducted from such benefit payment.

Non-Waiver Of Premium: Any Premium due under this Policy shall not be waived due to the payment of benefits or making of a claim under this Policy.

DESCRIPTION OF BENEFITS

The following Provisions explain the benefits available under this Policy.

MEDICAL EXPENSE BENEFIT

We will pay Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident or Sickness. These benefits are subject to the Deductibles, Coinsurance Rates, Benefit Maximums and other terms or limits shown in the Benefit Schedule.

Medical Expense Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Covered Expenses that the Insured receives; and
3. for which the initial treatment for the covered Injury or Sickness was received within the Maximum Benefit Period shown in the Benefit Schedule.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Covered Medical Expenses

1. Hospital semi-private room and board (or room and board in an intensive care unit); Hospital ancillary services (including, but not limited to, use of the operating room or emergency room)
2. Services of a Doctor or a registered nurse (R.N.)
3. Ambulance service to or from a Hospital
4. Laboratory tests
5. Radiological procedures
6. Anesthetics and their administration
7. Blood, blood products, artificial blood products, and the transfusion thereof
8. Physiotherapy
9. Chiropractic expenses on an inpatient or outpatient basis
10. Medicines or drugs administered by a Doctor or that can be obtained only with a Doctor's written prescription
11. Dental charges for Injury to sound, natural teeth
12. Emergency medical treatment of pregnancy
13. Therapeutic termination of pregnancy
14. Artificial limbs or eyes (not including replacement of these items)
15. Casts, splints, trusses, crutches, and braces (not including replacement of these items or dental braces)
16. Oxygen or rental equipment for administration of oxygen
17. Rental of a wheelchair or hospital-type bed
18. Rental of mechanical equipment for treatment of respiratory paralysis
19. Mental and Nervous Disorders: limited to one treatment per day. "Mental and Nervous Disorders" means neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind
20. Pregnancy and childbirth
21. New Born Nursery Care

EMERGENCY MEDICAL EVACUATION BENEFIT

We will pay Emergency Medical Evacuation Benefits as shown in the Benefit Schedule for expenses incurred for the medical evacuation of an Insured. Benefits are payable, if the Insured:

1. is traveling outside of his or her Home Country;
2. is traveling outside of 100 miles away from home;
3. suffers a Medical Emergency during the course of the Trip; and
4. requires Emergency Medical Evacuation.

Benefits will not be payable unless:

1. the Doctor ordering the Emergency Medical Evacuation certifies the severity of the Insured's Medical Emergency requires an Emergency Medical Evacuation;
2. all transportation arrangements made for the Emergency Medical Evacuation are by the most direct and economical conveyance and route possible;
3. the charges incurred are Medically Necessary and do not exceed the usual level of charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and
4. do not include charges that would not have been made if there were no insurance.

"Emergency Medical Evacuation" means the Insured's: 1) immediate transportation from the place where he/she suffer an Injury or Emergency Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained; or 2) transportation to his/her Home Country to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or an Emergency Sickness.

"Emergency Sickness" means: a sickness of such a nature that failure to get immediate medical care could put the person's life in danger or cause serious harm to the person's bodily functions.

An Emergency Medical Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such transportation.

Benefits will not be payable unless We authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance.

PERSONAL PROPERTY AND FINANCIAL INSTRUMENT REIMBURSEMENT BENEFIT

If an Insured sustains loss or damage to Personal Property or a Financial Instrument that is caused directly by a Covered Peril during his or her Trip, We will indemnify the Insured with respect to such loss or damage up to the maximum amount shown on the Schedule of Benefits after satisfaction of the Deductible. The Insured must take all reasonable precautions for the safety of any covered Personal Property and Financial Instruments. With respect to a covered loss, We will be entitled:

1. to take and keep possession of such property and to deal with salvage in a reasonable manner;
2. to repair or replace any property for which We have liability under this Benefit, at Our option. We will indemnify You for the actual cash value of the specific personal item claimed which is calculated on the basis of the depreciated standard and its average usable period.

Definitions

"Covered Peril" means loss or damage caused by: fire, explosion, lightning, collision, theft (unless committed by the Insured), burglary or robbery.

"Personal Property" means personal goods belonging to the Insured or for which the Insured is responsible and are taken or acquired by the Insured during the Trip and the personal effects owned by any Insured for personal use, adornment, or amusement.

"Financial Instrument" means coins, banknote, postal and money orders, signed travelers and other checks, letters of credit, travel tickets and credit cards.

Exclusions

We will not pay for:

1. Vehicles (including aircraft and other conveyances) or their accessories or equipment.
2. Loss or damage due to:
   a) Moth, vermin, insects or other animals;
   b) wear and tear; atmospheric or climatic conditions or gradual deterioration or defective materials or craftsmanship;
   c) Mechanical or electrical failure or inherent vice;
   d) Breaking, marring, scratching, wet or dampness, spoilage, being discolored, mildew, rust, frost, steam, mishandling, improper packing, improper stowage or rough handling;
   e) Any process of cleaning, restoring, repairing or alteration.
3. Any loss not reported to either the police or transport carrier.
4. Any loss due to confiscation or detention by customs or any other authority.
5. Loss or damage due to unexplained or mysterious disappearance.
6. Loss or damage due to theft unless reported to the police or competent authority.

In addition, We will not pay benefits for loss or damage caused by or resulting from loss or destruction of property resulting from any Insured voluntarily giving someone else possession of his or her property.

Additional exclusions that apply to this Benefit are shown in the Exclusions section of the Policy.

REPATRIATION OF REMAINS BENEFIT

We will pay Repatriation of Remains Benefits as shown in the Benefit Schedule for preparation and return of an Insured's body to his or her Home Country if he or she dies due to an Injury or Sickness. Covered Expenses include, but are not limited to:

1. expenses for embalming or cremation;
2. the least costly coffin or receptacle adequate for transporting the remains;
3. transporting the remains by the most direct and least costly conveyance and route possible.

Benefits will not be payable unless We authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance.

TRIP DELAY BENEFIT

We will pay this benefit up to the Maximum Number of Occurrences shown in the Benefit Schedule, if the Insured's Trip is delayed for more than 12 hours for reasonable, additional

accommodations and traveling expenses until travel becomes possible. Travel Delay must be caused by one of these reasons:

1. Injury, Sickness or death to either the Insured, Family Member or Travel Companion that occurs during the Trip;
2. carrier delay;
3. lost or stolen passport, travel documents or money;
4. Natural Disaster;
5. the Insured being delayed by a traffic accident while en route to a departure;
6. hijacking;
7. unpublished or unannounced strike;
8. civil disorder or commotion;
9. riot;
10. inclement weather which prohibits Common Carrier departure;
11. a Common Carrier strike or other job action;
12. equipment failure of a Common Carrier; or
13. the loss of the Insured's and/or Travel Companion's travel documents, tickets or money due to theft.

The Insured's Duties in the Event of Loss: The Insured must provide Us with proof of the Travel Delay such as a letter from the airline, cruise line, or Tour operator/ newspaper clipping/ weather report/ police report or the like and proof of the expenses claimed as a result of Trip Delay.

EXCLUSIONS

General Exclusions. We will not pay benefits for any loss or Injury that is caused by, or results from:

1. riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
2. travel in any Aircraft owned, leased or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder, if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year.
3. commission of or active participation in a riot or insurrection.
4. an accident if the Insured is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license.
5. intentionally self-inflicted injury; suicide or attempted suicide.
6. war or any act of war, whether declared or not.
7. a Covered Accident that occurs while an Insured is on active duty service in the military, naval or air force of any country or international organization. Upon receipt of proof of service, we will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
8. piloting or serving as a crewmember in any aircraft (unless otherwise provided in the Policy).
9. commission of, or attempt to commit, a felony.

Medical Expense Benefit Exclusions. In addition to the exclusions above, We will not pay Medical Expense Benefits for any loss, treatment or services resulting from or contributed to by:

1. routine physicals and care of any kind.

2. routine dental care and treatment.
3. routine nursery care.
4. cosmetic surgery, except for reconstructive surgery needed as the result of an Injury.
5. eye refractions or eye examinations for the purpose of prescribing corrective lenses or for the fitting thereof; eyeglasses, contact lenses, and hearing aids.
6. services, supplies, or treatment including any period of Hospital confinement which is not recommended, approved, and certified as Medically Necessary and reasonable by a Doctor, or expenses which are non-medical in nature.
7. treatment or service provided by a private duty nurse.
8. treatment by any Immediate Family Member or member of the Insured's household.
9. expenses incurred during travel for purposes of seeking medical care or treatment.
10. medical expenses for which the Insured would not be responsible to pay for in the absence of the Policy. Expenses incurred for services provided by any government Hospital or agency, or government sponsored-plan for which, and to the extent that, the Insured is eligible for reimbursement.
11. any treatment provided under any mandatory government program or facility set up for treatment without cost to any individual.
12. custodial care.
13. services or expenses incurred in the Insured's Home Country.
14. elective treatment, exams or surgery; elective termination of pregnancy.
15. expenses for services, treatment or surgery deemed to be experimental and which are not recognized and generally accepted medical practices in the United States.
16. expenses payable by any automobile insurance policy without regard to fault.
17. organ or tissue transplants and related services.
18. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation, whether United States federal or foreign law.
19. Pre-Existing Conditions, except as provided by the Policy
20. Injury sustained while participating in club, intramural, intercollegiate, interscholastic, professional or semi-professional sports.
21. Injury caused by or resulting from travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle, or a motor vehicle not designed primarily for use on public streets or highways.
22. Injury resulting from off-road motorcycling; scuba diving; jet, snow or water skiing; mountain climbing (where ropes or guides are used); sky diving; amateur automobile racing; automobile racing or automobile speed contests; bungee jumping; spelunking; white water rafting; surfing; or parasailing.
23. sexually transmitted diseases or immune deficiency disorders and related conditions. This exclusion does not apply to the care or treatment of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection, or any illness or disease arising from these medical conditions.

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

CLAIM PROVISIONS

Notice Of Claim: A claimant must give Us or Our authorized representative written (or authorized electronic or telephonic) notice of claim within 90 days after any loss covered by this Policy occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify the Insured and the Policy Number.

Claim Forms: Upon receiving written notice of claim, We will send claim forms to the claimant within 15 days. If We do not furnish such claim forms, the claimant will satisfy the requirements of written proof of loss by sending the written (or authorized electronic or telephonic) proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

Proof Of Loss: Written (or authorized electronic or telephonic) proof of loss must be sent to the agent authorized to receive it. Written (or authorized electronic or telephonic) proof must be given within 90 days after the date of loss. If it cannot be provided within that time, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted if it is sent later than one year from the time proof is otherwise required.

Claimant Cooperation Provision: Failure of a claimant to cooperate with Us in the administration of a claim may result in the termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Time Payment Of Claims: Any benefits due will be paid when We receive written (or authorized electronic or telephonic) proof of loss.

Payment Of Claims: If the Insured dies, any death benefits or other benefits unpaid at the time of the Insured's death will be paid to the beneficiary. If no beneficiary is on record with Us or Our authorized agent, payment will be made to the first surviving class of the following to the Insured's:

1. spouse;
2. children, in equal shares (If a child is a minor, benefits will be paid to the legal guardian);
3. mother or father;
4. estate.

All other benefits due and not assigned will be paid to the Insured, if living.

Otherwise, the benefits may, at our option, be paid:

1. according to the beneficiary designation; or
2. to the Insured's estate.

If a benefit due is payable to:

1. the Insured's estate; or
2. the Insured or a beneficiary who is either a minor or is not competent to give a valid release for the payment,

We may pay any amount due to some other person in an amount not to exceed $1,000. The other person will be one who we believe is entitled to the payment and who is related to the Insured or the beneficiary by blood or marriage. We will be relieved of further responsibility to the extent of any payment made in good faith.
We may pay benefits directly to any Hospital or person rendering covered services, unless the Insured requests otherwise in writing. The Insured must make the request no later than the time he or she files a written proof of loss.

Beneficiary: The Insured may designate a beneficiary. The Insured has the right to change the beneficiary at any time by written (or electronic and telephonic) notice. If the Insured is a minor,

his or her parent or guardian may exercise this right for him or her. The change will be effective when We or Our authorized agent receive it. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change.

Assignment: At the request of the Insured or his or her parent or guardian, if the Insured is a minor, medical benefits may be paid to the provider of service. Any payment made in good faith will end our liability to the extent of the payment.

Physical Examinations: We have the right to have a Doctor of Our choice examine the Insured as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We will pay the cost of the examination.

Legal Actions: No lawsuit or action in equity can be brought to recover on this Policy: (1) before 60 days following the date proof of loss was given to Us; or (2) after 3 years following the date proof of loss is required.

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 or all of the following methods.

1. A request for lump sum payment of the amount overpaid, or paid in error.
2. Reduction of any proceeds payable under this Policy by the amount overpaid, or paid in error.
3. Taking any other action available to Us.

Subrogation: We may recover any benefits paid under this Policy to the extent an Insured is paid for the same Injury or Sickness by a third party, another insurer, or the Insured's uninsured motorists insurance. We may only be reimbursed to the amount of the Insured's recovery. Further, We have the right to offset future benefits payable to the Insured under this Policy against such recovery.

We may file a lien in an Insured's action against the third party and have a lien on any recovery that the Insured receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. We shall have a right to recovery of the full amount of benefits paid under this Policy for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Insured. We will not be responsible for the Insured's attorney's fees or other costs.

Upon request the Insured must complete the required forms and return them to Us or Our authorized agent. The Insured must cooperate fully with Us or Our representative in asserting its right to recover. The Insured will be personally liable for reimbursement to Us to the extent of any recovery obtained by the Insured from any third party. If it is necessary for Us to institute legal action against the Insured for failure to repay Us, the Insured will be personally liable for all costs of collection, including reasonable attorneys' fees.

GENERAL PROVISIONS

Entire Contract; Changes: This Policy (including the Application and any Riders or Endorsements), are the entire contract. Only Our authorized officer can authorize a change or waive any provisions in this Policy. To be valid, any change or waiver must be in writing (or

authorized electronic or telephonic communications). The approval must be noted on or attached to this Policy. No agent has the authority to change or to waive any part of this Policy.

Time Limit on Certain Defenses: After two years form the date of issue of this Policy no misstatements, except from fraudulent misstatements, made by the applicant in the application will be used to void the Policy or deny a claim for loss incurred commencing after the expiration of such two-year period.
Fraudulent Claims: The making by the Insured of any fraudulent claims shall render this Policy null and void from the Effective Date and all claims under this Policy shall be forfeited.

Clerical Error: If a clerical error is made, it will not affect the insurance of any Insured. No error will continue the insurance of an Insured beyond the date it should end under this Policy terms.

Payment of Premium: Coverage is not effective unless the required premium has been paid.

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

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

Chubb. Insured.℠

CHUBB

CHUBB GROUP
U.S. PRIVACY NOTICE

FACTS	WHAT DOES THE CHUBB GROUP DO WITH YOUR PERSONAL INFORMATION?
Why?	Insurance companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: ▪ Social Security number and payment history ▪ insurance claim history and medical information ▪ account transactions and credit scores When you are no longer our customer, we continue to share information about you as described in this notice.
How?	All insurance companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons insurance companies can share their customers' personal information; the reasons the Chubb Group chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Chubb share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes – information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For our affiliates to market to you	No	We don't share
For nonaffiliates to market to you	No	We don't share
Questions?	**Call 1-800-258-2930 or go to** https://www2.Chubb.com/us-en/privacy.aspx	

Who is providing this notice?	The Chubb Group. A list of these companies is located at the end of this document.
What we do	
How does Chubb Group protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We restrict access to personal information to our employees, affiliates' employees, or others who need to know that information to service the account or to conduct our normal business operations.
How does Chubb Group collect my personal information?	We collect your personal information, for example, when you ▪ apply for insurance or pay insurance premiums ▪ file an insurance claim or provide account information ▪ give us your contact information We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only ▪ sharing for affiliates' everyday business purposes – information about your creditworthiness ▪ affiliates from using your information to market to you ▪ sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ▪ Our affiliates include those with a Chubb name and financial companies, such as Westchester Fire Insurance Company and Great Northern Insurance Company.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ▪ Chubb does not share with nonaffiliates so they can market to you.
Joint Marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. ▪ Our joint marketing partners include categories of companies such as banks.

Other important information

For Insurance Customers in AZ, CA, CT, GA, IL, MA, ME, MN, MT, NV, NC, NJ, OH, OR, and VA only: Under state law, under certain circumstances, you have the right to see the personal information about you that we have on file. To see your information, write Chubb Group Attention: Privacy Inquiries, 202 Hall's Mill Road, P.O. Box 1600, Whitehouse Station, NJ 08889-1600. Chubb may charge a reasonable fee to cover the costs of providing this information. If you think any of the information is not accurate, you may write us. We will let you know what actions we take. If you do not agree with our actions, you may send us a statement. If you want a full description of privacy rights that we will protect in accordance with the law in your home state, please contact us and we will provide it. We may disclose information to certain third parties, such as law enforcement officers, without your permission.

For Nevada residents only: We may contact our existing customers by telephone to offer additional insurance products that we believe may be of interest to you. Under state law, you have the right to opt out of these calls by adding your name to our internal do-not-call list. To opt out of these calls, or for more information about your opt out rights, please contact our customer service department. You can reach us by calling 1-800-258-2930, emailing us at privacyinquiries@Chubb.com, or writing to Chubb Group, Attention: Privacy Inquiries, 202 Hall's Mill Road, P.O. Box 1600, Whitehouse Station, NJ 08889-1600. You are being provided this notice under Nevada state law. In addition to contacting Chubb, Nevada residents can contact the Nevada Attorney General for more information about your opt out rights by calling 775-684-1100, emailing bcpinfo@ag.state.nv.us, or by writing to: Office of the Attorney General, Nevada Department of Justice, Bureau of Consumer Protection: 100 North Carson Street, Carson City, NV 89701.

For Vermont residents only: Under state law, we will not share information about your creditworthiness within our corporate family except with your authorization or consent, but we may share information about our transactions or experiences with you within our corporate family without your consent.

Chubb Group Companies Providing This Notice

This notice is being provided by the following Chubb Group companies to their customers located in the United States: ACE American Insurance Company, ACE Capital Title Reinsurance Company, ACE Fire Underwriters Insurance Company, ACE Insurance Company of the Midwest, ACE Life Insurance Company, ACE Property and Casualty Insurance Company, Agri General Insurance Company, Atlantic Employers Insurance Company, Bankers Standard Fire and Marine Company, Bankers Standard Insurance Company, Century Indemnity Company, Chubb Custom Insurance Company, Chubb Indemnity Insurance Company, Chubb Insurance Company of New Jersey, Chubb Lloyds Insurance Company of Texas, Chubb National Insurance Company, Executive Risk Indemnity Inc., Executive Risk Specialty Insurance Company, Federal Insurance Company, Great Northern Insurance Company, Illinois Union Insurance Company, Indemnity Insurance Company of North America, Insurance Company of North America, Pacific Employers Insurance Company, Pacific Indemnity Company, Penn Millers Insurance Company, Texas Pacific Indemnity Company, Vigilant Insurance Company, Westchester Fire Insurance Company and Westchester Surplus Lines Insurance Company.

Chubb Group

Notice of HIPAA Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is effective as of June 15, 2018.

The Chubb Group of Companies, as affiliated covered and hybrid entities, (the "Company") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information, and to inform you about:

- The Company's uses and disclosures of Protected Health Information ("PHI")
- Your privacy rights with respect to your PHI;
- The Company's duties with respect to your PHI;
- Your right to file a complaint with the Company and to the Secretary of the U.S.

Department of Health and Human Services ("HHS"); and

- The person or office to contact for further information regarding the Company's privacy practices.

PHI includes all individually identifiable health information transmitted or maintained by the Company, regardless of form (e.g. oral, written, electronic).

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), regulates PHI use and disclosure by the Company. You may find these rules at *45 Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

I. Notice of PHI Uses and Disclosures

A. Required Uses and Disclosures

Upon your request, the Company is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of Health and Human Services to investigate or determine the Company's compliance with the privacy regulations.

B. Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

The Company and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Company also may also disclose PHI to a plan sponsor for purposes related to treatment, payment and health care operations and as otherwise permitted under HIPAA to the extent the plan documents restrict the use and disclosure of PHI as required by HIPAA.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Company may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including establishing employee contributions, claims management, obtaining payment under a contract of reinsurance, utilization review and pre-authorizations). For example, the Company may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Company.

Health care operations include, but are not limited to, underwriting, premium rating and other insurance activities relating to creating or reviewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Company may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions. The Company will not use or disclose PHI that is genetic information for underwriting purposes.

The Company also may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you.

C. Uses and Disclosures that Require Your Written Authorization

The Company will not use or disclose your PHI for the following purposes without your specific, written authorization:

- Use and disclosure of psychotherapy notes, except for your treatment, Company training programs, or to defend Company against litigation filed by you.
- Use and disclosure for marketing purposes, except for face to face communications with you.
- Use and disclosure that constitute the sale of your PHI. The Company does not sell the PHI of its customers.

Except as otherwise indicated in this notice, uses and disclosures of PHI will be made only with your written authorization subject to your right to revoke such authorization. You may revoke an authorization by submitting a written revocation to the Company at any time. If you revoke your authorization, the Company will no longer use or disclose your PHI under the authorization. However, any use or disclosure made in reliance of your authorization before its revocation will not be affected.

D. Uses and Disclosures Requiring Authorizations or Opportunity to Agree or Disagree Prior to the Use or Release

If you authorize in writing the Company to use or disclose your own PHI, the Company may proceed with such use or disclosure without meeting any other requirements and the use or disclosure shall be consistent with the authorization.

Disclosure of your PHI to family members, other relatives or your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

E. Uses and Disclosures for which Consent, Authorization or Opportunity to Object is Not Required

Use and disclosure of your PHI is allowed without your authorization or request under the following circumstances:

(1) When required by law.

(2) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls and to conduct post-market surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

(3) When authorized by law to report information about abuse, neglect or domestic violence. In such case, the Company will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor’s parents or other representatives although there may be circumstances under federal or state law where the parents or other representatives may not be given access to the minor’s PHI.

(4) The Company may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(5) The Company may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Company that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

(6) When required for law enforcement purposes (for example, to report certain types of wounds).

(7) For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Company's best judgment.

(8) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent The Company may also disclose your PHI to organ procurement organizations.

(9) The Company may use or disclose PHI for government-approved research, subject to conditions.

(10) When consistent with applicable law and standards of ethical conduct if the Company, in good faith, believes the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(11) For certain government functions such as related to military service or national security.

(12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

(13) That is "incident to" an otherwise permitted use or disclosure of PHI by the Company.

II. Rights of Individuals

A. Right to Request Restrictions on Use and Disclosure of PHI

You may request the Company to restrict its use and disclosure of your PHI to carry out treatment, payment or health care operations, or to restrict its use and disclosure to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Company may not be required to agree to your request, unless you have paid out of pocket in full for services, depending on the specific facts.

The Company will accommodate reasonable requests to receive communications of PHI by alternative means or alternative locations, such as a location other than your home. The Company will accommodate this request if you state in writing that you would be in danger from receiving communications through the normal means.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

B. Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Company maintains the PHI.

"*Protected Health Information"* (PHI) includes all individually identifiable health information transmitted or maintained by the Company, regardless of form.

"*Designated Record Set*" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by

or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Company is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of Health and Human Services.

C. Right to Amend PHI

You have the right to request the Company to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Company has 60 days after the request to act on the request. A single 30-day extension is allowed if the Company is unable to comply with the deadline. If the request is denied in whole or part, the Company must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

You or your personal representative(s) will be required to complete a form to request amendment of the PHI in your designated record set.

D. Right to Receive an Accounting of PHI Uses and Disclosures

Upon your request, the Company will provide you with an accounting of disclosures by the Company of your PHI during the six (6) years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) based upon your own written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Company will charge a reasonable, cost-based fee for each subsequent accounting.

E. Right to Obtain a Paper Copy of This Notice Upon Request (Even if you have consented to receive this notice electronically)

To obtain a paper copy of this notice contact: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

F. Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or

- An individual who is the parent of a minor child.

The Company retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

III. The Company's Duties

The Company is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices and to notify affected individuals of a breach of unsecured PHI. The Company is required to abide by the terms of this notice.

The Company reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Company prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Company still maintains PHI. This notice and any revised version of this notice will be posted on the Company's internal website or mailed.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Company or other privacy practices stated in this notice.

A. "Minimum Necessary" Standard

When using or disclosing PHI, or when requesting PHI from another covered entity, the Company will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of HHS;
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required for the Company's compliance with legal regulations.

This notice does not apply to information that has been "de-identified." *De-identified information* is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Company may use or disclose "summary health information" to a plan sponsor for obtaining premium bids or modifying, amending or terminating the Company, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Company Sponsor has provided health benefits under the Company; and from which identifying information has been deleted in accordance with HIPAA.

IV. Your Right to File a Complaint with the Company or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Company in care of: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.

Your complaint must be submitted within 180 days of when you believe the violation occurred. The Company will not retaliate against you for filing a complaint.

V. Contact Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

VI. Chubb Group Legal Entities

This following is a list of the Chubb Group companies located in the United States: ACE American Insurance Company, ACE Fire Underwriters Insurance Company, ACE Insurance Company of the Midwest, ACE Life Insurance Company, ACE Property and Casualty Insurance Company, Agri General Insurance Company, Atlantic Employers Insurance Company, Bankers Standard Insurance Company, Century Indemnity Company, Chubb Custom Insurance Company, Chubb Indemnity Insurance Company, Chubb Insurance Company of New Jersey, Chubb Lloyds Insurance Company of Texas, Chubb National Insurance Company, Executive Risk Indemnity Inc. Executive Risk Specialty Insurance Company, Federal Insurance Company, Great Northern Insurance Company, Illinois Union Insurance Company, Indemnity Insurance Company of North America, Insurance Company of North America, Pacific Employers Insurance Company, Pacific Indemnity Company, Penn Millers Insurance Company, Vigilant Insurance Company, Westchester Fire Insurance Company, Westchester Surplus Lines Insurance Company, Combined Insurance Company of America, and Combined Life Insurance Company of New York. These companies have designated themselves as *hybrid entities* and only those designated health care components identified by such companies are subject to HIPAA. In addition, these companies are legally separate affiliated companies under common ownership and have designated themselves as a *single covered entity* for purposes of HIPAA compliance.

MASSACHUSETTS GRIEVANCE PROCEDURE

GENERAL INFORMATION

If you do not agree with the payment or denial of a claim or service, you, your authorized representative and/or your health care provider have the right to appeal the decision. When appealing, you and your authorized representative should state all of the facts as to why you believe the claim should be reconsidered and provide any additional supporting documentation. If we require any specific forms, such as a written authorization of representation or a medical records release consent form, such forms will be provided to you within five (5) calendar days of receipt of your request for appeal.

You may contact ACE American Insurance Company at:

ACE American Insurance Company
CHUBB Customer Service Department
P.O. Box 1000
Philadelphia, Pennsylvania 19105-1000
1-800-352-4462

Internal Inquiry Process

You, your authorized representative or a health care provider acting on your behalf and with your consent, have the right to request an internal inquiry at any time. We will answer any questions and/or resolve concerns communicated on your behalf to your satisfaction within three (3) business days of receipt. This internal inquiry process is not to be used for review of an adverse determination which must be reviewed through the internal grievance process described below.

If the internal inquiry process fails to answer your questions or resolve your concerns to your satisfaction within three (3) business days, we may, at our option, subject your inquiry to the internal grievance process.

Our response to your inquiry will include, in writing, a clear, concise and complete description of our internal inquiry process. We will advise you of our process in receiving and addressing inquiries as expeditiously as possible, and we will determine whether the inquiry has been resolved to your satisfaction. The notice will also advise you that if the internal inquiry process has not resolved the inquiry to your satisfaction, you have the right to have the inquiry processed as an internal grievance, including the reduction of an oral inquiry to writing by us, and a written acknowledgment and written resolution of the grievance.

We will maintain records of all inquiries communicated to us, along with our responses, for a period of two years. These records are subject to inspection by the Commissioner of Insurance and the Department.

Internal Grievance Process

If the internal inquiry process does not resolve the inquiry to your satisfaction, you have the right to have the inquiry processed as an internal grievance. We will provide you with a clear, concise and complete written description of our internal grievance process. If you need assistance in resolving such grievances, you may contact our customer service department at the toll-free number given at the beginning of this notice, or you may contact the Office of Patient Protection at:

Commonwealth of Massachusetts

Managed Care Consumer Advisory Board
Ombudsman
Office of Patient Protection
1-800-436-7757

We will accept grievances by telephone, in person, by mail or by electronic means. Any grievance communicated to us orally, either by you or your authorized representative, will be reduced to writing and a copy will be forwarded to you and your authorized representative within 48 hours of receipt, unless you or your authorized representative and we mutually agree, in writing, to waive or extend the time limit.

Any grievance filed that requires review of medical records will require your signature or that of your authorized representative. We will promptly provide to you and your authorized representative any forms required to authorize the release of medical and treatment information relevant to the grievance to us or our review organization, in a manner consistent with state and federal law. You and your representative will have access to any medical information and records relevant to the grievance.

We will maintain records of all grievances communicated to us, along with our responses, for a period of seven years. These records are subject to inspection by the Commissioner of Insurance and the Department.

Within 15 business days of receipt of the grievance, we will send you and your authorized representative a written acknowledgment, except in those cases where we have reduced an oral grievance to writing or except where this time period has been waived or extended by mutual agreement.

Within 30 business days of receipt of the grievance, we will provide you and your authorized representative with a written resolution. If the grievance requires the review of medical records, the 30 business day period will not begin to run until you or your authorized representative submits a signed authorization for release of medical records and treatment information. In the event that we do not receive such signed authorization within 30 business days of our receipt of the grievance, we may, at our own discretion, issue a resolution of the grievance without review of some or all of the medical records.

The 30 business day time period for written resolution of a grievance that does not require review of medical records begins on the day immediately following the three business day time period for processing inquiries, if the inquiry has not been addressed within that period of time; or on the day you or your authorized representative notifies us that you or your authorized representative is not satisfied with our response to your inquiry.

All grievances will be reviewed by an individual(s) who is knowledgeable about the matters at issue in the grievance. Grievances of adverse determinations will be reviewed with the participation of an individual(s) who did not participate in any of our prior decisions on the grievance. In at least one level of review of grievances of adverse determinations, this individual(s) will be an actively practicing health care professional in the same or a similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment that is the subject of the grievance.

Our written response to you will include identification of the specific information considered and an explanation of the basis for our decision. In the case of a grievance that involves an adverse determination, the written resolution will include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and at a minimum, will include:

- the specific information upon which the adverse determination was based;
- a discussion of your presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;
- specific alternate treatment options covered under your policy, if any;
- references to and explanations of applicable clinical practice guidelines and review criteria, and;
- a notification to you and your authorized representative of the procedures for requesting an external review, including the procedures for requesting an expedited external review.

We may offer you or your authorized representative the opportunity for reconsideration of our final adverse determination where relevant medical information:

- was received too late to review within the 30 business day time limit, or;
- was not received but is expected to become available with a reasonable time period following our written resolution.

If you or your authorized representative chooses to request reconsideration, we must agree in writing with you to a new time period for review, but in no event greater than 30 business days from the agreement to reconsider the grievance. The time period for requesting external review will begin to run from the date of the resolution of the reconsidered grievance.

Expedited Review of Grievances

We will provide for an expedited resolution concerning our coverage or provision of immediate and urgently needed services, which information will include, but not be limited to:

- a written resolution before your discharge from a hospital if the grievance is submitted by you or your authorized representative while you are an inpatient in a hospital. If the expedited review process results in an adverse determination regarding the continuation of inpatient care, the written resolution will advise you and your authorized representative of the opportunity to request an expedited external review and the opportunity to request continuation of services.
- Provisions for the automatic reversal of decisions denying coverage for services or durable medical equipment, pending the outcome of the internal grievance process, within 48 hours (or earlier for durable medical equipment at the option of a physician responsible for your treatment or proposed treatment) of receipt of certification by the physician that, in the physician's opinion:
  - The service or use of durable medical equipment at issue in the grievance is medically necessary;
  - The denial of coverage for such services or durable medical equipment would create a substantial risk of serious harm to you, and;
  - Such risk of serious harm is so immediate that the provision of such services or durable medical equipment should not await the outcome of the normal grievance process.
- Provisions that require that, in the event a physician exercises the option of automatic reversal earlier than 48 hours for durable medical equipment, the physician must further certify as to the specific, immediate and severe harm that will result to you absent action within the 48 hour time period.

Expedited Process for Insured with Terminal Illness

When you or another covered person has a terminal illness, and you or your authorized representative submits a grievance, we will provide a resolution within 5 business days from the receipt of such grievance. If the expedited review process continues to affirm denial of coverage or treatment to a covered person with a terminal illness, we will provide you or your authorized representative, with 5 business days of the decision:

- a statement setting forth the specific medical and scientific reasons for denying coverage or treatment, and;
- a description of alternative treatment, services or supplies covered under or provided by the policy, if any.

If the expedited review process continues to affirm denial of coverage or treatment to a covered person with a terminal illness, you and your authorized representative have the right to request a conference:

- The conference will be scheduled within 10 days of receiving the request.
- The conference will be held within 5 business days of the request, however, if the treating physician determines, after consultation with our medical director or his designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered under the policy, would be materially reduced if not provided at the earliest possible date.
- You and/or your authorized representative may attend the conference.
- At the conference, you, your authorized representative, and our representative with authority to determine the disposition of the grievance will review the information provided.

Failure to Meet Time Limits

If we do not act within the time limits required by the foregoing processes, the grievance will be deemed resolved in your favor. Time limits include any extensions made by mutual agreement between us and you or your authorized representative.

Coverage or Treatment Pending Resolution of Internal Grievance

If you file a grievance concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment will remain in effect at our expense through completion of the internal grievance process regardless of the final internal grievance decision. Ongoing coverage or treatment includes only that medical care that, at the time it was initiated, was authorized by us or a utilization review organization, unless such care is provided as a result of a physician's option for the automatic reversal of decisions, as explained under the Expedited Review of Grievances section, and does not include medical care that was terminated pursuant to a specific time or episode-related exclusion from the covered person's policy.

Confidentiality

Except as specifically authorized by an appropriate release signed by you or your authorized representative, we will not release medical and treatment information obtained as part of the internal inquiry or grievance process unless otherwise required or authorized by law.

External Review

You and/or your authorized representative, if you are aggrieved by a final adverse determination issued by us or an utilization review organization may request an external review by filing a request in writing with the Office of Patient Protection within 45 days of your receipt of written notice of the final adverse determination. You or your authorized representative will be responsible for a $25.00 fee to the Office of Patient Protection, which should accompany your request for an external review. Please note that the fee may be waived by the Office if it determines that the payment of the fee would result in an extreme financial hardship to you.

Expedited External Review

You and/or your authorized representative may request to have your request for review processed as an expedited external review.

Any request for an expedited external review shall contain a certification, in writing, from a physician, that delay in the providing or continuation of health care services that are the subject of a final adverse determination, would pose a serious and immediate threat to your health or the health of a covered person.

Upon a finding that a serious and immediate threat to you, or to another covered person, exists, the Office of Patient Protection shall qualify such request as eligible for an expedited external review.

Form and Manner of Request for an External Review

Your or your authorized representative's request for an external review shall:

- be on a form prescribed by the Department;
- include your or your authorized representative's signature consenting to the release of medical information;
- include a copy of the written final adverse determination issued by us; and
- include the $25.00 fee required.

Continuation of Services

If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending. Any such request must be made before the end of the second business day following receipt of the final adverse determination. The review panel may order the continuation of coverage or treatment where it determines that substantial harm to your or another covered person's health may result in the absence of such continuation or such other good cause as the review panel may determine. Any such continuation of coverage shall be at our expense regardless of the final external review determination.

Definitions

"Adverse determination" means a determination, based upon review of information provided, by us or our designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

"Emergency medical condition" means a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who

possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy.

“Medically necessary” or “medical necessity” means health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:

1. the service is the most appropriate available supply or level of service for the Insured in question considering potential benefits and harm to the individual;
2. is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving outcome; or
3. for services and interventions not in widespread use, is based on scientific evidence.