Global Assistance – SafeTrip

UnitedHealthcare Global Faculty and Staff Welcome Guide University of Nebraska

October 2019

UnitedHealthcare® Global

Global Assistance – SafeTrip Contact Information

Resource	Your Information	Phone/Email
Emergency Response Center **Available 24-hours-a-day, 7-days-a-week**	**Case Manager will request:** • Your name • Your school and campus • A description of the situation • A phone number to reach you	**p: 1.800.527.0218 or 1.410.453.6330** **e: assistance@uhcglobal.com (The email inbox is also available and monitored 24/7)**

The University of Nebraska has established an international travel insurance policy through UnitedHealthcare Global. Benefits-eligible employees and temporary employees are automatically covered by this policy when they travel outside of the United States on University of Nebraska business. University of Nebraska students, including student employees and graduate assistants, traveling internationally on trips associated with the University should contact the Education Abroad office on their campus to purchase coverage before their departure.
UnitedHealthcare Global has a dedicated team of professionals who are available to support University of Nebraska travelers. If you experience an emergency while traveling abroad, or if you have questions about doctors or hospitals or resources in the areas where you will be traveling, use the contact information above to reach UHCG's Emergency Response Center.

The following pages describe the University of Nebraska's policy in more detail. They also provide information about accessing UHCG's online resources, including medical assistance services, travel assistance services, and worldwide intelligence for destinations around the world.

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SafeTrip
uhcsafetrip.com
Identification Card

UnitedHealthcare Global ID Card

Support provided worldwide 24-hours a day.

The University of Nebraska has chosen to provide its travelers with a travel protection plan called SafeTrip. When traveling, you can now feel confident that you are in safe hands if an emergency arises. As part of your SafeTrip travel protection plan, UnitedHealthcare Global provides you with medical and travel-related assistance services. Listed on your ID card are the telephone numbers for the worldwide UnitedHealthcare Global Emergency Response Center. When you call, we will ask for your name, your university's name and campus, the UnitedHealthcare Global ID number shown on your card, and a description of your situation. You should carry your UnitedHealthcare Global SafeTrip ID card with you at all times.

Assistance & Insurance Services (including but not limited to)

Medical Assistance Services	• Worldwide medical and dental referrals • Monitoring of treatment • Facilitation of hospital payments • Relay of insurance and medical information	• Medication and vaccine transfers • Updates to family, & home physician • Hotel arrangements • Replacement corrective lenses & medical devices
Travel Assistance Services	• Language services • Emergency travel arrangements • Transfer of funds	• Replacement of lost or stolen travel documents • Legal referrals • Message transmittals
Worldwide Destination Intelligence	• Destination Profiles	The Destination Profiles are available by calling the UnitedHealthcare Global Emergency Response Center at 1.800.527.0218.
Travel Medical Insurance Benefits	UHCG has partnered with United States Fire Insurance Company to bring this coverage to you. Travel Medical Insurance is provided by and underwritten by United States Fire Insurance Company. • Medical and accident coverage up to maximum amount selected at purchase • Emergency medical evacuation and return to home country • Emergency medical reunion transportation to join a hospitalized member • Return of minor children • Return of mortal remains	

How to use UnitedHealthcare Global's services

24 hours a day, 7 days a week, 365 days a year

If you have a medical or travel issue, contact us for assistance. Simply call the Emergency Response Center at +1.410.453.6330 or email us at: **assistance@uhcglobal.com**.

If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact UnitedHealthcare Global's 24-hour Emergency Response Center. We'll then take the appropriate action to assist you and monitor your care until the situation is resolved.

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01/19 MBR-D-1774-2

UnitedHealthcare® Global

Please cut your ID card along the dotted line and fold in the center.

UnitedHealthcare® Global

SafeTrip
uhcsafetrip.com

Client Name: University of Nebraska Faculty and Staff

UHCG ID#: 902525657

Notice to Physicians/Hospitals: Call immediately for benefits verification and procedures – completed claim form required.

Call 24 hours a day (multilingual). If you don't have access to a phone, email for assistance: **assistance@uhcglobal.com**

Underwritten by U.S. Fire Insurance Company / Claims administered by Co-ordinated Benefit Plans, LLC. Please refer to your policy document for coverage and terms.

UnitedHealthcare Global Emergency Response Center
24 hours a day, 7 days a week, 365 days a year

United States **+1.410.453.6330**
Assistance@uhcglobal.com
1.800.527.0218 (toll free within U.S. & Canada)

If the condition is an emergency, you should immediately call local emergency services or go to the nearest physician or hospital without delay. Then contact the 24-hour Emergency Response Center. If you have a travel problem, simply call or email for assistance. Carrier charges may be incurred. The Emergency Response Center can obtain a call back number to minimize telecom charges to you.

A multilingual case manager will ask for your name, your organization's name, the number shown on the front of your ID card, and a description of the situation. We will immediately begin assisting you.

GLOBAL ASSISTANCE

GLOBAL INTELLIGENCE CENTER ACCOUNT

How to:

As part of the University of Nebraska's program with UnitedHealthcare Global, UHCG provides access to some excellent online resources at no additional cost. In order to access these in-depth resources, NU faculty and staff will first need to create an account on UHCG's Global Intelligence Center. The Global Intelligence Center provides access to medical, security, and travel information for countries around the world. Log on to the UnitedHealthcare Global Intelligence Center to access medical, security and/or travel tools providing information on your country of destination. Included in your program, you have access to Medical Intelligence Reports, WorldWatch (Security Intelligence), and Pre-Travel Planning.

1 **Navigate to www.members.uhcglobal.com**

2 **Click "Create User."**

3 **Enter your UHC Global ID Number 902525657, click "Next."**
ID number is located on the front of your UnitedHealthcare Global Member ID Card.

4 **Read and agree to the terms of use, click "Next."**

5 **Enter your account information, click "Next."**
Username, Password, Email, Security Question and Answer.

6 **Complete your user information, click "Finish."**
Enter your first name, last name, gender and primary phone number.

UnitedHealthcare Global formerly known as FrontierMEDEX®

For over 30 years UnitedHealthcare Global, formerly FrontierMEDEX, brings together health care professionals, medical assistance, local knowledge and a global footprint to provide international-standard medical care all over the world, offshore or on land.

*Some customers of UnitedHealthcare Global have combinations of these tools included in their program, but not all do. Please check your program or call your administrator to determine if you are eligible for access.

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UnitedHealthcare® Global

Benefits when traveling outside of the United States

UnitedHealthcare Global

SAFETRIP SCHOLASTIC

For U.S. Residents Traveling Outside the United States

The University of Nebraska has chosen to provide its travelers with a travel protection plan called SafeTrip**.** SafeTrip provides you with international travel assistance services and travel medical insurance.

- Travel assistance coverage is provided by United Healthcare Global (UHCG).
- Travel Medical Insurance is provided by and underwritten by United States Fire Insurance Company.

The emergency assistance services are detailed on the following pages. For full travel insurance details, please see the enclosed Certificate of Insurance.

Emergency Assistance Services provided by UnitedHealthcare Global

Medical Assistance Services
Travel Assistance Services
Destination Intelligence

Travel Insurance Features

Travel Delay (6 hours)	$500
Non-Medical Emergency Evacuation	$150,000
Medical Evacuation	$500,000
Emergency Reunion	Included
Return of Dependent Child	Included
Return of Remains	Included
24 Hour-AD&D	$10,000
Accident & Sickness Medical Expense	$500,000
Dental due to Accident	$500

HOW TO USE UNITEDHEALTHCARE GLOBAL SERVICES

24 hours a day, 7 days a week, 365 days a year

If you have a medical or travel problem, simply call us for assistance. Our telephone numbers are printed on your ID card. Either call or email at:

Baltimore, Maryland +1-410-453-6330
Assistance@uhcglobal.com

An assistance coordinator will ask for Your name, Your company or group name, the UHCG ID number shown on Your card, and a description of Your situation. **If the condition is an emergency, You should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center**. We will then take the appropriate action to assist You and monitor Your care until the situation is resolved.

Payments arranged by UHCG:
Most Physicians and hospitals will provide you with the necessary medical treatment will either send their bill directly to UHCG Insurance Services, or in the case of small dollar amounts, may ask You to pay at time services are rendered. Ask the hospital or Physician to contact UHCG. UHCG will confirm Your protection plan coverage and arrange for prompt payments. You will be asked to pay for any deductible amount or items not covered by Your plan.

Payments made by You:
If You are required to pay for medical treatment, obtain a signed receipt and a signed statement by a Physician describing the problem and the treatment. Once Your other insurance has processed Your claim, submit a copy of their final disposition along with a UHCG Insurance Services claim form and a copy of Your receipts to:

UnitedHealthcare Global Claim Administrator
P.O. Box 20874
Tampa, FL 33622
1-877-693-8530 / Fax: 1-800-560-6340
Email Address: Team1@cbpinsure.com
For claim forms or questions, call between 8:30 A.M. and 5:00 P.M. Monday through Friday Eastern Time.

WORLDWIDE EMERGENCY ASSISTANCE SERVICES

These non-insurance services are provided by UnitedHealthcare Global.

MEDICAL ASSISTANCE SERVICES

Worldwide Medical and Dental Referrals: Upon your request, UHCG will provide referrals to pre-approved physicians, hospitals, dentists, and dental clinics in the area you are traveling in order to assist you in locating appropriate treatment and quality care.

Monitoring of Treatment: As and to the extent permissible, UHCG will continually monitor your medical condition. Physician Advisors will provide consultative and advisory services to UHCG in relation to your medical condition, including review and analysis of the quality of medical care received by you.

Facilitation of Hospital Payment: Upon securing payment or a guarantee to reimburse, UHCG will either wire or guarantee funds needed for admitting you into a hospital for medical treatment. You are responsible for the payment of the cost of medical care and treatment, including hospital expenses.

Relay of Insurance and Medical Information: Upon your request and authorization, UHCG will relay your insurance benefit information and/or medical records and information to a health care provider or treating physician, as appropriate and permissible, to help prevent delays or denials of medical care. UHCG will also assist with hospital admission and discharge planning.

Medication and Vaccine Transfers: In the event a medication or vaccine is not available locally, or a prescription medication is lost or stolen, UHCG will coordinate the transfer of the medication or vaccine to you upon the prescribing physician's authorization, if it is legally permissible.

Updates to Family, Employer, and Home Physician: Upon your approval, UHCG will provide periodic case updates to appropriate individuals designated by you in order to keep them informed.

Hotel Arrangements: UHCG will assist you with the arrangement of hotel stays and room requirements before or after hospitalization or for ongoing care.

Replacement of Corrective Lenses and Medical Devices: UHCG will assist with the replacement of corrective lenses or medical devices if they are lost, stolen, or broken during travel.

TRAVEL ASSISTANCE SERVICES

Replacement of Lost or Stolen Travel Documents: UHCG will assist you in taking the necessary steps to replace passports, tickets, and other important travel documents.

Emergency Travel Arrangements: UHCG will make new reservations for airlines, hotels, and other travel services for you in the event of: (a) an Illness or Injury, (b) a Security Evacuation, and (c) during a Political Evacuation.

Transfer of Funds: UHCG will provide you with an emergency cash advance subject to UHCG first securing funds from you (via a credit card) or your family.

Legal Referrals: Should you require legal assistance, UHCG will direct you to a duly licensed attorney in or around the area where you are located.

Language Services: UHCG will provide immediate interpretation assistance to you in a variety of languages in an emergency situation. If a requested interpretation is not available or the requested assistance is related to a non-emergency situation, UHCG will provide you with referrals to interpreter services. Written translations and other custom requests, including an on-site interpreter, will be subject to an additional fee.

Message Transmittals: You may send and receive emergency messages toll-free, 24-hours a day, through the UHCG Emergency Response Center.

WORLDWIDE DESTINATION INTELLIGENCE

Destination Profiles: When preparing for travel, You can contact the Emergency Response Center to have a pre-trip destination report sent to You. This report draws upon the UHCG intelligence database of over 280 cities covering subject such as health and security risks, immunizations, vaccinations, local hospitals, crime, emergency phone numbers, culture, weather, transportation information, entry and exit requirements, and currency. Our global medical and security database of over 170 countries and 280 cities is continuously updated and includes intelligence from thousands of worldwide sources**.**

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

TRAVEL PROTECTION PLAN CERTIFICATE

This Certificate of Insurance describes the insurance benefits underwritten by United States Fire Insurance Company, herein referred to as the Company and also referred to as We, Us and Our. The insurance benefits vary from program to program. Please refer to the accompanying Confirmation of Benefits, which provides the Insured, also referred to as You or Your, with specific information about the program You purchased. You should contact the Company immediately if You believe that the Confirmation of Benefits is incorrect.

If You are not satisfied for any reason, You may return Your Certificate Document to the Plan Administrator within 15 days after receipt. Your plan payment will be refunded, provided You have not already departed on the Trip or filed a claim. When so returned, the coverage under the Certificate is void from the beginning.

Signed for **United States Fire Insurance Company** By:

Marc J. Adee
Chairman and CEO

James Kraus
Secretary

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

Renewal: Coverage under this Certificate is not renewable.

SHORT TERM COVERAGE

NON-RENEWABLE

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SCHEDULE OF BENEFITS

Benefit Per Trip **Maximum Benefit Amount/Principal Sum**

Part A – Travel Arrangement Protection

Travel Delay..... $500
Non-Medical Emergency Evacuation..... $150,000

Part B – Travel Insurance Benefits

Accidental Death & Dismemberment..... $10,000
Accident & Sickness Medical Expense..... $500,000
Emergency Medical Evacuation and
Repatriation of Remains…… $500,000

SECTION I. COVERAGES

TRAVEL DELAY

Benefits will be paid for: the non-refundable, unused portion of the Prepaid expenses for Your Trip; and reasonable accommodation, meal, telephone call and local transportation expenses incurred by You, up to the Maximum Benefit Amount shown in the Schedule of Benefits, if You are delayed for 6 hours or more while en route to or from, or during Your Trip, due to:

a) any delay of a Common Carrier (the delay must be certified by the Common Carrier);
b) a traffic accident in which You or Your Traveling Companion are not directly involved (must be substantiated by a police report);
c) lost or stolen passports, travel documents or money (must be substantiated by a police report);
d) quarantine, hijacking, Strike, Natural Disaster, terrorism or riot;
e) a documented weather condition preventing You from getting to the point of departure.

You must provide the following documentation when presenting a claim for these benefits:

a) Written confirmation of the reasons for delay from the Common Carrier whose delay resulted in the loss, including but not limited to; scheduled departure and return times and actual departure and return times.

Benefits will not be paid for any expenses, which have been reimbursed, or for any services that have been provided by the Common Carrier.

These benefits will not duplicate any other benefits payable under the Certificate or any coverage(s) attached to the Certificate.

NON-MEDICAL EMERGENCY EVACUATION

You are eligible for benefits, up to the Maximum Benefit Amount shown in the Schedule of Benefits, for all reasonable expenses incurred for Your transportation to the nearest place of safety, or to Your primary place of residence, if You must leave Your Trip for a Non-Medical Emergency Evacuation Covered Reason, as defined below.

Non-Medical Emergency Evacuation must occur within 14 days of any covered event. Arrangements will be by the most appropriate and economical means available and consistent with Your health and safety. Benefits are only payable for arrangements made by the assistance company.

Non-Medical Emergency Evacuation Covered Reasons: We will pay for the Non-Medical Emergency Evacuation Benefits listed above if, while on Your Trip, a formal recommendation in the form of a Travel Advisory or Travel Warning from the U.S. State Department, is issued for You to leave a country You are visiting on Your Trip due to:

1. a Natural Disaster;
2. civil, military or political unrest; or
3. Your being expelled or declared a persona non-grata by a country You are visiting on Your Trip.

Non-Medical Emergency Evacuation Exclusions: We do not cover:

1. loss or expense recoverable under any other insurance or through an employer;
2. loss or expense arising from or attributable to:
   (a) fraudulent or criminal acts committed or attempted by You;
   (b) alleged violation of the laws of the country You are visiting, unless We determine such allegations to be fraudulent; or
   (c) failure to maintain required documents or visas;
3. loss or expense arising from or attributable to:
   (a) debt, insolvency, business or commercial failure;
   (b) the repossession of any property; or
   (c) Your non-compliance with a contract, license, or permit;

4. loss or expense arising from or due to liability assumed by You under any contract.

These benefits will not duplicate any other benefits payable under the Certificate or any coverage(s) attached to the Certificate.

24-HOUR ACCIDENTAL DEATH AND DISMEMBERMENT

We will pay the percentage of the Principal Sum shown in the Table of Losses below when You, as a result of an Injury occurring during Your Trip sustain a loss shown in the Table of Losses below. The loss must occur within one hundred eighty-one (181) days after the date of the Injury causing the loss. The Principal Sum is the Maximum Benefit Amount shown in the Schedule of Benefits.

Table of Losses	
Type of Loss	**Benefit Amount**
Loss of Life	100% of Principal Sum
Loss of both hands	100% of Principal Sum
Loss of both feet	100% of Principal Sum
Loss of both eyes	100% of Principal Sum
Loss of one hand and one foot	100% of Principal Sum
Loss of one hand and one eye	100% of Principal Sum
Loss of one foot and one eye	100% of Principal Sum
Loss of one hand	50% of Principal Sum
Loss of one foot	50% of Principal Sum
Loss of one eye	50% of Principal Sum
Loss of Speech	50% of Principal Sum
Loss of Hearing (Both Ears)	50% of Principal Sum
Loss of thumb and index finger of the same hand	25% of Principal Sum

Loss of hand or hands, or foot or feet, means severance at or above the wrist joint or ankle joint, respectively.

Loss of eye or eyes means the total and irrecoverable loss of the entire sight thereof.

Loss of Speech means the loss of the ability to talk or speak as a result of a Covered Accident. The loss must be certified by a Legally Qualified Physician that the loss of speech is permanent with no reasonable expectation of recovery.

Loss of Hearing means the total and complete loss of the ability to hear any sound as a result of a Covered Accident. The loss must be certified by a Legally Qualified Physician that the loss of hearing is permanent with no reasonable expectation of recovery.

Only one of the amounts shown above (the largest applicable) will be paid for Injuries resulting from one accident.

The benefits for loss of: (a) two limbs; (b) both eyes; or (c) one limb and one eye is payable only when such loss results from the same accident.

The Principal Sum is shown in the Schedule of Benefits.

EXPOSURE AND DISAPPEARANCE

We will pay benefits for covered losses that result from Your being unavoidably exposed to the elements because of a Covered Accident occurring during Your Trip. The loss must occur within 365 days after the event that caused the exposure.

If, while insured under this Coverage, You are unavoidably exposed to the elements because of a Covered Accident and suffer a loss for which benefits are payable under this Coverage, such loss will be covered.

If, while insured under this Coverage, You are in an Accident resulting in the disappearance, sinking or damaging of an air or water conveyance on which You are covered by this Coverage, and if Your body has not been found within 52 weeks from the date of the Accident, it will be presumed, unless there is evidence to the contrary, that You suffered loss of life as a result of those Injuries.

These benefits will not duplicate any other benefits payable under the Certificate or any coverage(s) attached to the Certificate.

ACCIDENT & SICKNESS MEDICAL EXPENSE

Benefits will be paid for the Covered Expense incurred, up to the Maximum Benefit Amount shown in the Schedule of Benefits, as a result of a Covered Accidental Injury or covered Sickness, which first occurs during Your Trip. Only Covered Expenses incurred during Your Trip will be reimbursed. Expenses incurred after Your Trip are not covered.

Benefits will include up to $500 expenses for emergency dental treatment due to Injury to natural teeth.

Benefits will not be paid in excess of the Usual and Customary Charges.

For the purpose of this benefit:

"Covered Expense" means expense incurred only for the following:

1. The medical services, prescription drugs, prosthetics, therapeutic services ordered or prescribed by a Legally Qualified Physician as Medically Necessary for treatment;

2. Hospital or ambulatory medical-surgical center services (including expenses for a cruise ship cabin or hotel room, not already included in the cost of the Your Trip, if recommended as a substitute for a hospital room for recovery from a Covered Accidental Injury or covered Sickness);
3. Transportation furnished by a professional ambulance company to and/or from a Hospital.

These benefits will not duplicate any benefits payable under the Certificate or any coverage(s) attached to the Certificate.

EMERGENCY MEDICAL EVACUATION AND RETURN OF REMAINS

When You suffer loss of life for any reason or incur a Sickness or Injury during the course of Your Trip, the following benefits are payable, up to the Maximum Benefit Amount shown in the Schedule of Benefits.

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

   If You are traveling alone and will be hospitalized for more than 3 consecutive days and Emergency Evacuation is not imminent, benefits will be paid to transport one person, chosen by You, by Economy Transportation, for a single visit to and from Your bedside.

   If You are in the Hospital for more than 3 consecutive days and Your dependent children who are under 18 years of age and accompanying You on Your Trip are left unattended, Economy Transportation will be paid to return the dependents to their home (with an attendant, if considered necessary by the authorized travel assistance company).

2. **Return of Remains**: In the event of Your death during a Trip, the expense incurred will be paid for minimally necessary casket or air tray, preparation and transportation of Your remains to Your primary place of residence in the United States of America or to the place of burial.

   If benefits are payable and You have other insurance that may provide benefits for this same loss, We reserve the right to recover from such other insurance. You shall:
   a) notify the Company of any other insurance;
   b) help the Company exercise the Company's rights in any reasonable way that the Company may request, including the filing and assignment of other insurance benefits;
   c) not do anything after the loss to prejudice the Company's rights; and
   d) reimburse to the Company, to the extent of any payment the Company has made, for benefits received from such other insurance.

These benefits will not duplicate any other benefits payable under the Certificate or any coverage(s) attached to the Certificate.

SECTION II. DEFINITIONS

"Accident" means a sudden, unexpected unusual specific event that occurs at an identifiable time and place, and shall also include exposure resulting from a mishap to a conveyance in which You are traveling.

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

"Covered Accident" means an Accident that occurs while coverage is in force and results in a loss for which benefits are payable.

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

"Eligible Person" means a citizen or resident of the United States of America who is booked to travel on a Trip, completes an enrollment form if applicable, and for whom the required premium has been paid.

"Family Member" means any of the following: Your or Your Traveling Companion's legal spouse (or common-law spouse where legal), legal guardian or ward, son or daughter (adopted, foster, step or in-law), brother or sister (includes step or in-law), parent (includes step or in-law), grandparent (includes in-law), grandchild, aunt, uncle, niece or nephew, or domestic partner.

"Home" means Your primary place of residence.

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

"Injury" or "Injuries" means bodily harm caused by an Accident which: 1) occurs while Your coverage is in effect under the Certificate; and 2) requires examination and treatment by a Legally Qualified Physician. The Injury must be the direct cause of loss and must be independent of all other causes and must not be caused by, or result from, Sickness.

"Insured" means a person(s) who is booked to travel on a Trip, completes the enrollment form and for whom the required premium is paid, also referred to as You and Your.

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

"Maximum Benefit Amount" means the maximum amount payable for coverage provided to You as shown in the Schedule of Benefits.

"Medically Fit to Travel" means based on assessment a Legally Qualified Physician has advised You, a Traveling Companion or Family Member booked to travel with You in writing that there is no medical condition, illness, Injury or Sickness that would likely interfere with a Trip at the time of purchase of Coverage for a Trip**.**

"Medically Necessary" means a service which is appropriate and consistent with the treatment of the condition in accordance with accepted standards of community practice.

"Medical Treatment" means examination and treatment by a Legally Qualified 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.

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

"Participating Organization" means an organization which elects to offer coverage under a Policy by completing a participation agreement that has been accepted by the Company

"Scheduled Departure Date" means the date on which You are originally scheduled to leave on Your Trip.

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

"Sickness" means an illness or disease of the body which: 1) requires examination and treatment by a Legally Qualified Physician, and 2) commences while Your coverage is in effect.

"Strike" means any labor disagreement resulting in a stoppage of work: (a) as a result of a combined effort of workers which was unannounced and unpublished at the time travel services were purchased; and (b) which interferes with the normal departure and arrival of a Common Carrier.

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

"Transportation Expense" means the cost of Medically Necessary conveyance, personnel, and services or supplies.

"Travel Advisory or Travel Warning" means U.S. State Department communication advising caution in traveling to specified destinations due to reasons such as armed violence, civil or political unrest, high incidence of crime (specially kidnapping and/or murder), natural disaster or outbreak of one or more contagious diseases.

"Travel Arrangements" means: (a) transportation; (b) accommodations; and (c) other specified services arranged by the Travel Supplier for Your Trip. Air arrangements covered by this definition also include any direct round trip air flights booked by others, to and from Your Scheduled Trip Departure and return cities, provided the dates of travel for the air flights are within 7 total days of Your scheduled Trip dates.

"Traveling Companion" means a person or persons whose names appear with Yours on the same Travel Arrangements and who, during Your Trip and who during Your Trip will accompany You. A group or tour organizer, sponsor or leader is not a Traveling Companion as defined, unless sharing accommodations in the same room, cabin, condominium unit, apartment unit or other lodging with You.

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

"Trip" means a scheduled trip for which coverage for Travel Arrangements is requested and the premium is paid prior to Your actual or Scheduled Departure Date of Your Trip for which coverage is requested and the premium is paid.

"Us", "We", "Our" means United States Fire Insurance Company**.**

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

SECTION III. INSURING PROVISIONS

Who Is Eligible For Coverage:
A citizen or resident of the United States of America who is booked to travel on a Trip, completes the enrollment form and for whom the required premium is paid. Eligibility for purchase will be determined at time of claim. If it is determined that a person or Trip is not eligible for coverage, any claim for benefits will be denied and premium will be refunded.

When Coverage Begins – Coverage Effective Date:

All Coverages: Coverage begins when You depart on the first Travel Arrangement (or alternate travel arrangement if You must use an alternate travel arrangement to reach Your Trip destination) for Your Trip. This is Your "Effective Date" and time for all other coverages.

When Coverage Ends – Coverage Termination Date:

All Coverages: Your coverage automatically ends on the earlier of: 1) the date Your Trip is completed; 2) the Scheduled Return Date; 3) Your arrival at Your return destination on a round-trip, or the destination on a one-way trip; 4) cancellation of Your Trip covered by the Certificate. Termination of the Certificate will not affect a claim for loss that occurs after premium has been paid.

SECTION IV. GENERAL EXCLUSIONS

Benefits are not payable for any loss due to, arising or resulting from:

1. an act of declared or undeclared war;
2. participating in maneuvers or training exercises of an armed service, except while participating in weekend or summer training for the reserve forces of the United States, including the National Guard;
3. riding or driving in organized races, or speed or endurance competitions or events;
4. mountaineering (engaging in the sport of scaling mountains generally requiring the use of picks, ropes, or other special equipment);
5. participating in extreme skiing (skiing outside marked trails or heli-skiing), speed contests (not including any of the regatta races), or scuba diving if the depth exceeds 50 feet or if You are not certified to dive and a dive master is not present during the dive;
6. piloting or learning to pilot or acting as a member of the crew of any aircraft;
7. the commission of or attempt to commit a felony or being engaged in an illegal occupation;
8. dental treatment (except as coverage is otherwise specifically provided herein);
9. amounts which exceed the Maximum Benefit Amount for each coverage as shown in the Schedule of Benefits;
10. any amount paid or payable under any Worker's Compensation, Disability Benefit or similar law;
11. Elective Treatment and Procedures;
12. medical treatment during or arising from a Trip undertaken for the purpose or intent of securing medical treatment;
13. due to 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 chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act and regardless of any other sequence thereto.
14. an assessment from a Legally Qualified Physician advising You in writing that You, a Traveling Companion or Family Member booked to travel with You are not Medically Fit to Travel, as defined in the Certificate, at the time of purchase of Coverage for a Trip.

SECTION V. GENERAL PROVISIONS

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

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

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

Time of Payment of Claims: We, or Our designated representative, will pay the claim immediately (or within 30 days) after receipt of acceptable proof of loss.

Payment of Claims: Benefits for loss of life will be paid to Your designated beneficiary. If a beneficiary is not otherwise designated by You, benefits for loss of life will be paid to the first of the following surviving preference beneficiaries:

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

All other Benefits will be paid directly to You, unless otherwise directed. Any accrued benefits unpaid at Your death will be paid to Your estate. If You have assigned Your benefits, We will honor the assignment if a signed copy has been filed with us. We are not responsible for the validity of any assignment.

All or a portion of all benefits provided by the Certificate may, at Our option, be paid directly to the provider of the service(s) to You. All benefits not paid to the provider will be paid to You.

If any benefit is payable to: (a) an Insured who is a minor or otherwise not able to give a valid release; or (b) the Insured's estate, We may pay up to $1,000 to the Insured's beneficiary or any relative whom We find entitled to the payment. Any payment made in good faith shall fully discharge Us to any party to the extent of such payment.

Physician Examination and Autopsy: The Company, at the expense of the Company, may have You examined when and as often as is reasonable while the claim is pending. The Company may have an autopsy done (at the expense of the Company) where it is not forbidden by law.

Legal Actions: All policy terms will be interpreted under the laws of the state in which the Policy was issued. No legal action may be brought to recover on the Policy within 60 days after written Proof of Loss has been furnished. No legal action for a claim may be brought against Us after 3 years from the time written Proof of Loss is required to be furnished.

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

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

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

PRIVACY POLICY AND PRACTICES

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

Your Privacy is Our Concern

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

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

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

What do we do with the information collected about you?

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

To whom do we disclose information about you?

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

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

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

How to contact Us

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

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

When used throughout this document "Company", "Our", "We", or "Us" means:
United States Fire Insurance Company

GRIEVANCE PROCEDURES

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

DEFINITIONS

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

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

INFORMAL GRIEVANCE PROCEDURE

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

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

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

FORMAL GRIEVANCE PROCEDURE

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

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

First Level Review

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

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

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

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

Second Level Review

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

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

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

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

The panel must be comprised of persons who:

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

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

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

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

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

EXPEDITED REVIEW

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

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

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance. We will not provide an expedited review for retrospective reviews of Adverse Determinations.

Benefits when traveling to Hawaii and Alaska

All registered Faculty, staff and employees, traveling to Hawaii or Alaska on school sponsored programs can purchase benefits for Medical Evacuation which includes Emergency Reunion, Return of Dependent Children and Repatriation of Remains to your home. Coverage is available for Dependents and Children.

To purchase the benefits, please email to SafeTrip_Scholastic@uhcglobal.com your full name, home address and travel dates. An invoice will be submitted to the University of Nebraska. Daily rate is $0.60.

Upon completion of the registration, you will receive your UnitedHealthcare Global ID Card via email.

SAFETRIP SCHOLASTIC

For U.S. Residents Traveling to Hawaii and/or Alaska

The University of Nebraska has chosen to provide its travelers with a travel protection plan called SafeTrip. **SafeTrip Scholastic** provides you with international travel assistance services and travel medical insurance. UHCG has partnered with United States Fire Insurance Company to bring this coverage to you.

- Travel assistance coverage is provided by United Healthcare Global (UHCG).
- Medical Evacuation insurance is provided and underwritten by United States Fire Insurance Company

The emergency assistance services are detailed on the following pages. For full travel insurance details, please see the enclosed Certificate of Insurance.

Emergency Assistance Services provided by UnitedHealthcare Global

Medical Assistance Services

Travel Assistance Services

Destination Intelligence

Travel Insurance Features

Medical Evacuation	$500,000
Emergency Reunion	Included
Return of Dependent Child	Included
Return of Remains	Included

HOW TO USE UNITEDHEALTHCARE GLOBAL SERVICES

24 hours a day, 7 days a week, 365 days a year

If you have a medical or travel problem, simply call us for assistance. Our telephone numbers are printed on your ID card. Either call or email at:

Baltimore, Maryland +1-410-453-6330

Assistance@uhcglobal.com

An assistance coordinator will ask for Your name, Your company or group name, the UHCG ID number shown on Your card, and a description of Your situation. **If the condition is an emergency, You should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center**. We will then take the appropriate action to assist You and monitor Your care until the situation is resolved.

Payments for Medical Treatment:

Most Physicians and hospitals will provide you with the necessary medical treatment will either send their bill directly to Your Primary Health Insurance. Please provide your Primary Health Insurance card to the Physician or hospital.

WORLDWIDE EMERGENCY ASSISTANCE SERVICES

These non-insurance services are provided by UnitedHealthcare Global.

MEDICAL ASSISTANCE SERVICES

Worldwide Medical and Dental Referrals: Upon your request, UHCG will provide referrals to pre-approved physicians, hospitals, dentists, and dental clinics in the area you are traveling in order to assist you in locating appropriate treatment and quality care.

Monitoring of Treatment: As and to the extent permissible, UHCG will continually monitor your medical condition. Physician Advisors will provide consultative and advisory services to UHCG in relation to your medical condition, including review and analysis of the quality of medical care received by you.

Medication and Vaccine Transfers: In the event a medication or vaccine is not available locally, or a prescription medication is lost or stolen, UHCG will coordinate the transfer of the medication or vaccine to you upon the prescribing physician's authorization, if it is legally permissible.

Updates to Family, Employer, and Home Physician: Upon your approval, UHCG will provide periodic case updates to appropriate individuals designated by you in order to keep them informed.

Hotel Arrangements: UHCG will assist you with the arrangement of hotel stays and room requirements before or after hospitalization or for ongoing care.

Replacement of Corrective Lenses and Medical Devices: UHCG will assist with the replacement of corrective lenses or medical devices if they are lost, stolen, or broken during travel.

TRAVEL ASSISTANCE SERVICES

Replacement of Lost or Stolen Travel Documents: UHCG will assist you in taking the necessary steps to replace passports, tickets, and other important travel documents.

Emergency Travel Arrangements: UHCG will make new reservations for airlines, hotels, and other travel services for you in the event of: (a) an Illness or Injury, (b) a Security Evacuation, and (c) during a Political Evacuation.

Transfer of Funds: UHCG will provide you with an emergency cash advance subject to UHCG first securing funds from you (via a credit card) or your family.

Legal Referrals: Should you require legal assistance, UHCG will direct you to a duly licensed attorney in or around the area where you are located.

Language Services: UHCG will provide immediate interpretation assistance to you in a variety of languages in an emergency situation. If a requested interpretation is not available or the requested assistance is related to a non-emergency situation, UHCG will provide you with referrals to interpreter services. Written translations and other custom requests, including an on-site interpreter, will be subject to an additional fee.

Message Transmittals: You may send and receive emergency messages toll-free, 24-hours a day, through the UHCG Emergency Response Center.

WORLDWIDE DESTINATION INTELLIGENCE

Destination Profiles: When preparing for travel, You can contact the Emergency Response Center to have a pre-trip destination report sent to You. This report draws upon the UHCG intelligence database of over 280 cities covering subject such as health and security risks, immunizations, vaccinations, local hospitals, crime, emergency phone numbers, culture, weather, transportation information, entry and exit requirements, and currency. Our global medical and security database of over 170 countries and 280 cities is continuously updated and includes intelligence from thousands of worldwide sources**.**

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

TRAVEL PROTECTION PLAN CERTIFICATE

This Certificate of Insurance describes the insurance benefits underwritten by United States Fire Insurance Company, herein referred to as the Company and also referred to as We, Us and Our. The insurance benefits vary from program to program. Please refer to the accompanying Confirmation of Benefits, which provides the Insured, also referred to as You or Your, with specific information about the program You purchased. You should contact the Company immediately if You believe that the Confirmation of Benefits is incorrect.

If You are not satisfied for any reason, You may return Your Certificate Document to the Plan Administrator within 15 days after receipt. Your plan payment will be refunded, provided You have not already departed on the Trip or filed a claim. When so returned, the coverage under the Certificate is void from the beginning.

Signed for **United States Fire Insurance Company** By:

Marc J. Adee
Chairman and CEO

James Kraus
Secretary

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

Renewal: Coverage under this Certificate is not renewable.

SHORT TERM COVERAGE

NON-RENEWABLE

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SCHEDULE OF BENEFITS

Benefit Per Trip **Maximum Benefit Amount/Principal Sum**

Part A – Travel Insurance Benefits

Emergency Medical Evacuation and

Repatriation of Remains…… $500,000

SECTION I. COVERAGES

EMERGENCY MEDICAL EVACUATION AND RETURN OF REMAINS

When You suffer loss of life for any reason or incur a Sickness or Injury during the course of Your Trip, the following benefits are payable, up to the Maximum Benefit Amount shown in the Schedule of Benefits.

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

   If You are traveling alone and will be hospitalized for more than 3 consecutive days and Emergency Evacuation is not imminent, benefits will be paid to transport one person, chosen by You, by Economy Transportation, for a single visit to and from Your bedside.

   If You are in the Hospital for more than 3 consecutive days and Your dependent children who are under 18 years of age and accompanying You on Your Trip are left unattended, Economy Transportation will be paid to return the dependents to their home (with an attendant, if considered necessary by the authorized travel assistance company).

2. **Return of Remains**: In the event of Your death during a Trip, the expense incurred will be paid for minimally necessary casket or air tray, preparation and transportation of Your remains to Your primary place of residence in the United States of America or to the place of burial.

   If benefits are payable and You have other insurance that may provide benefits for this same loss, We reserve the right to recover from such other insurance. You shall:
   a) notify the Company of any other insurance;
   b) help the Company exercise the Company's rights in any reasonable way that the Company may request, including the filing and assignment of other insurance benefits;
   c) not do anything after the loss to prejudice the Company's rights; and
   d) reimburse to the Company, to the extent of any payment the Company has made, for benefits received from such other insurance.

These benefits will not duplicate any other benefits payable under the Certificate or any coverage(s) attached to the Certificate.

SECTION II. DEFINITIONS

"Accident" means a sudden, unexpected unusual specific event that occurs at an identifiable time and place, and shall also include exposure resulting from a mishap to a conveyance in which You are traveling.

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

"Covered Accident" means an Accident that occurs while coverage is in force and results in a loss for which benefits are payable.

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

"Eligible Person" means a citizen or resident of the United States of America who is booked to travel on a Trip, completes an enrollment form if applicable, and for whom the required premium has been paid.

"Family Member" means any of the following: Your or Your Traveling Companion's legal spouse (or common-law spouse where legal), legal guardian or ward, son or daughter (adopted, foster, step or in-law), brother or sister (includes step or in-law), parent (includes step or in-law), grandparent (includes in-law), grandchild, aunt, uncle, niece or nephew, or domestic partner.

"Home" means Your primary place of residence.

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

"Injury" or "Injuries" means bodily harm caused by an Accident which: 1) occurs while Your coverage is in effect under the Certificate; and 2) requires examination and treatment by a Legally Qualified Physician. The Injury must be the direct cause of loss and must be independent of all other causes and must not be caused by, or result from, Sickness.

"Insured" means a person(s) who is booked to travel on a Trip, completes the enrollment form and for whom the required premium is paid, also referred to as You and Your.

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

"Maximum Benefit Amount" means the maximum amount payable for coverage provided to You as shown in the Schedule of Benefits.

"Medically Fit to Travel" means based on assessment a Legally Qualified Physician has advised You, a Traveling Companion or Family Member booked to travel with You in writing that there is no medical condition, illness, Injury or Sickness that would likely interfere with a Trip at the time of purchase of Coverage for a Trip**.**

"Medically Necessary" means a service which is appropriate and consistent with the treatment of the condition in accordance with accepted standards of community practice.

"Medical Treatment" means examination and treatment by a Legally Qualified 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.

"Participating Organization" means an organization which elects to offer coverage under a Policy by completing a participation agreement that has been accepted by the Company

"Scheduled Departure Date" means the date on which You are originally scheduled to leave on Your Trip.

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

"Sickness" means an illness or disease of the body which: 1) requires examination and treatment by a Legally Qualified Physician, and 2) commences while Your coverage is in effect.

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

"Transportation Expense" means the cost of Medically Necessary conveyance, personnel, and services or supplies.

"Travel Arrangements" means: (a) transportation; (b) accommodations; and (c) other specified services arranged by the Travel Supplier for Your Trip. Air arrangements covered by this definition also include any direct round trip air flights booked by others, to and from Your Scheduled Trip Departure and return cities, provided the dates of travel for the air flights are within 7 total days of Your scheduled Trip dates.

"Traveling Companion" means a person or persons whose names appear with Yours on the same Travel Arrangements and who, during Your Trip and who during Your Trip will accompany You. A group or tour organizer, sponsor or leader is not a Traveling Companion as defined, unless sharing accommodations in the same room, cabin, condominium unit, apartment unit or other lodging with You.

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

"Trip" means a scheduled trip for which coverage for Travel Arrangements is requested and the premium is paid prior to Your actual or Scheduled Departure Date of Your Trip for which coverage is requested and the premium is paid.

"Us", "We", "Our" means United States Fire Insurance Company**.**

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

SECTION III. INSURING PROVISIONS

Who Is Eligible For Coverage:
A citizen or resident of the United States of America who is booked to travel on a Trip, completes the enrollment form and for whom the required premium is paid. Eligibility for purchase will be determined at time of claim. If it is determined that a person or Trip is not eligible for coverage, any claim for benefits will be denied and premium will be refunded.

When Coverage Begins – Coverage Effective Date:

All Coverages: Coverage begins when You depart on the first Travel Arrangement (or alternate travel arrangement if You must use an alternate travel arrangement to reach Your Trip destination) for Your Trip. This is Your "Effective Date" and time for all other coverages.

When Coverage Ends – Coverage Termination Date:

All Coverages: Your coverage automatically ends on the earlier of: 1) the date Your Trip is completed; 2) the Scheduled Return Date; 3) Your arrival at Your return destination on a round-trip, or the destination on a one-way trip; 4) cancellation of Your Trip covered by the Certificate. Termination of the Certificate will not affect a claim for loss that occurs after premium has been paid.

SECTION IV. GENERAL EXCLUSIONS

Benefits are not payable for any loss due to, arising or resulting from:

1. an act of declared or undeclared war;
2. participating in maneuvers or training exercises of an armed service, except while participating in weekend or summer training for the reserve forces of the United States, including the National Guard;
3. riding or driving in organized races, or speed or endurance competitions or events;
4. mountaineering (engaging in the sport of scaling mountains generally requiring the use of picks, ropes, or other special equipment);
5. participating in extreme skiing (skiing outside marked trails or heli-skiing), speed contests (not including any of the regatta races), or scuba diving if the depth exceeds 50 feet or if You are not certified to dive and a dive master is not present during the dive;
6. piloting or learning to pilot or acting as a member of the crew of any aircraft;
7. the commission of or attempt to commit a felony or being engaged in an illegal occupation;
8. dental treatment (except as coverage is otherwise specifically provided herein);
9. amounts which exceed the Maximum Benefit Amount for each coverage as shown in the Schedule of Benefits;
10. any amount paid or payable under any Worker's Compensation, Disability Benefit or similar law;
11. Elective Treatment and Procedures;
12. medical treatment during or arising from a Trip undertaken for the purpose or intent of securing medical treatment;
13. due to 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 chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act and regardless of any other sequence thereto.
14. an assessment from a Legally Qualified Physician advising You in writing that You, a Traveling Companion or Family Member booked to travel with You are not Medically Fit to Travel, as defined in the Certificate, at the time of purchase of Coverage for a Trip.

SECTION V. GENERAL PROVISIONS

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

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

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

Time of Payment of Claims: We, or Our designated representative, will pay the claim immediately (or within 30 days) after receipt of acceptable proof of loss.

Payment of Claims: Benefits for loss of life will be paid to Your designated beneficiary. If a beneficiary is not otherwise designated by You, benefits for loss of life will be paid to the first of the following surviving preference beneficiaries:

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

All other Benefits will be paid directly to You, unless otherwise directed. Any accrued benefits unpaid at Your death will be paid to Your estate. If You have assigned Your benefits, We will honor the assignment if a signed copy has been filed with us. We are not responsible for the validity of any assignment.

All or a portion of all benefits provided by the Certificate may, at Our option, be paid directly to the provider of the service(s) to You. All benefits not paid to the provider will be paid to You.

If any benefit is payable to: (a) an Insured who is a minor or otherwise not able to give a valid release; or (b) the Insured's estate, We may pay up to $1,000 to the Insured's beneficiary or any relative whom We find entitled to the payment. Any payment made in good faith shall fully discharge Us to any party to the extent of such payment.

Physician Examination and Autopsy: The Company, at the expense of the Company, may have You examined when and as often as is reasonable while the claim is pending. The Company may have an autopsy done (at the expense of the Company) where it is not forbidden by law.

Legal Actions: All policy terms will be interpreted under the laws of the state in which the Policy was issued. No legal action may be brought to recover on the Policy within 60 days after written Proof of Loss has been furnished. No legal action for a claim may be brought against Us after 3 years from the time written Proof of Loss is required to be furnished.

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

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

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

When used throughout this document "The Company", "Our", "We", or "Us" means:
United States Fire Insurance Company

PRIVACY POLICY AND PRACTICES

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

Your Privacy is Our Concern

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

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

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

What do we do with the information collected about you?

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

To whom do we disclose information about you?

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

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

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

How to contact Us

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

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

When used throughout this document "Company", "Our", "We", or "Us" means:
United States Fire Insurance Company

GRIEVANCE PROCEDURES

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

DEFINITIONS

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

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

INFORMAL GRIEVANCE PROCEDURE

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

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

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

FORMAL GRIEVANCE PROCEDURE

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

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

First Level Review

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

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

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

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

Second Level Review

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

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

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

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

The panel must be comprised of persons who:

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

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

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

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

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

EXPEDITED REVIEW

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

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

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance. We will not provide an expedited review for retrospective reviews of Adverse Determinations.

Contact us:

When you need help, our multilingual **Emergency Response** Center is here to support you.

PHONE:

+1.800.527.0218 or @ 410.453.6330

EMAIL:

assistance@uhcglobal.com (The email inbox is also available and monitored 24/7)

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