Cigna Health and Life Insurance Company
Hartford, Connecticut 06152

BUSINESS TRAVEL INSURANCE

POLICYHOLDER: Fanatics, Inc.

ADDRESS: 8100 Nations Way, Jacksonville, FL 32256

ACCOUNT NUMBER: 07953A

EFFECTIVE DATE: October 15, 2018 through October 14, 2019

ANNIVERSARY DATE: October 1st

This policy is issued in Delaware and shall be governed by its laws.

This Policy takes effect as of 12:01 A.M Eastern Standard Time on the Effective Date, and shall continue in effect as long as the premium is paid on or before the premium due date as herein agreed, unless and until either the Policyholder or the Company terminate the Policy in accordance with the provision entitled "Termination of the Policy" or as otherwise stated in the Policy. Policy years shall be determined from the Policy Anniversary Date as specified above.

THIS IS A LIMITED POLICY
IT PAYS BENEFITS FOR SPECIFIC MEDICAL ILLNESS AND INJURY OCCURING WHILE ON INTERNATIONAL BUSINESS TRAVEL
PLEASE READ IT CAREFULLY
Non-Participating

The Insurance Company and the Policyholder have agreed to all of the terms of this policy.

Anna Krishtul, Corporate Secretary

Richard Toro, Registrar

DE_BTI-010000

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INSURANCE SCHEDULE – MEDICAL ILLNESS AND INJURY

Covered Medical Class	Class Definition	Effective Date
Class 1 (employee)	All full-time active employees and Board Members who are traveling on the business of, or at the expense of, the Policyholder outside their country of residence or permanent assignment for no more than 180 consecutive days per one trip.	10-15-2018
Class 2 (dependents)	Not Covered.	N/A

MEDICAL ILLNESS AND INJURY INSURANCE	
Calendar Year Medical Benefit Maximum	$500,000
Calendar Year Deductible	$0
Coinsurance (paid by Cigna)	100%
Out of Pocket Coinsurance Maximum	None
Prescription Drug	100% of covered expenses, when medically necessary while on an approved international business trip, this benefit includes replacement medicine for lost prescriptions that are medically necessary during an international trip
Emergency Dental (includes dental accident & alleviation of sudden unexpected pain)	Unlimited, subject to the calendar year maximum
Personal Deviation (Sojourn)	7 days, when taken in conjunction with an approved business trip
Room and Board Inside the U.S.	Average Semi-Private Room Rate
Room and Board Outside the U.S.	Average Semi-Private Room Rate
Pre-Existing Condition	None, subject to the calendar year maximum
Medical Evacuation & Repatriation	$250,000
War Risk	Covered
Accidental Death and Dismemberment (AD&D)	Covered. Please refer to AD&D schedule for benefit information.

Maximum Reimbursable Charge

Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or

A percentage of a schedule {In-Network U.S. – Not Applicable, Out of Network – 150%}that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurance Company.

Note:
The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles and coinsurance.

INSURANCE SCHEDULE - ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Covered (AD&D) Class	Class Definition	Effective Date
Class 1 (employee)	All full-time active employees and Board Members who are traveling on the business of, or at the expense of, the Policyholder outside their country of residence or permanent assignment for no more than 180 consecutive days per one trip.	10-15-2018

ACCIDENTAL DEATH OR DISMEMBERMENT INSURANCE

The insurance provides benefits for accidental death or dismemberment. The amount that may be payable is based on the Amount of Principal Sum.

Amount of Principal Sum	$200,000
War Risk	Covered
Aggregate Limit of Liability **This includes forms of transportation such as air, bus train, and boat**	$1,000,000 for all covered persons Not more than the Policy Aggregate Maximum specified above will be paid for all Covered Losses for all Covered Persons as the result of any one Covered Accident. If this amount does not allow all Covered Persons to be paid the amounts this policy otherwise provides, the amount paid for each Loss bears to the Aggregate Limit of Liability.
Table of Losses and Benefits	% of Principal Sum
Loss of Life or Two or more members	100%
Loss of Speech AND Hearing	100%
Loss of Speech OR Hearing	One-half (1/2) the Principal Sum
Loss of One member	One-half (1/2) the Principal Sum
Thumb and index finger from the same hand	One-fourth (1/4) the Principal Sum

Such payment shall be in addition to any other indemnity payable as of the date of loss, but only one (1) amount, the larger applicable amount, shall be payable for all such losses resulting from one accident. The "Principal Sum" is the amount specified as such in the Schedule.

Member: shall mean a hand, foot, or eye

Loss: shall mean, with respect to:

- hands and feet, actual severance through or above wrist or ankle joints;
- with respect to eyes, entire irrecoverable loss of sight;
- with respect to speech, the total irrecoverable loss of speech which does not allow audible communications in any degree
- with respect to hearing which cannot be corrected by any hearing aid or device
- with respect to thumb and index finger means complete severance through or above the metacarpophalangeal joints, (the joints between the fingers and the hand).

SCHEDULE OF AFFILIATES

The following affiliates are covered under this Policy on the effective dates listed below. A newly-acquired affiliate may be covered under this Policy on the date it is acquired as long as the Policyholder notifies Us within 90 days of its acquisition and pays the required premium. If we are not notified within the required time period, the affiliate will be covered on the date we agree in writing to provide coverage and receive the required premium. Individuals who are employed by the affiliate on its effective date of coverage are eligible for coverage on that date.

AFFILIATE NAME	LOCATION	EFFECTIVE DATE
As Designated by the Policyholder		

ADMINISTRATIVE PROVSIONS

Dependent Eligibility	See Employee Class on the Insurance Schedule. Please refer to the medical insurance schedule to see if dependents are covered. For your dependents to be insured, they will need to be traveling with the covered person and outside their country of residence or permanent assignment for no more than 180 consecutive days per one trip. Dependents are not eligible for Accidental Death and Dismemberment coverage.
Employee Eligibility	See Employee class on the insurance schedule Employee must be traveling on International business or personal deviation /sojourn if listed as a covered benefit on the medical insurance schedule, at the expense of the Policyholder outside their country of residence or permanent assignment for no more than 180 consecutive days per one trip
Grace Period	This Policy will have a 31 day grace period. This means that if a premium is not paid on or before it is due, it may be paid during the 31 day grace period. During this time, the Policy will stay in force. The Policyholder is liable for the payment of any premium while coverage is in force.
Premiums	Premium is calculated based on the estimated weeks of travel and plan options chosen by the Policyholder. If the Company determines that the number of weeks of travel is materially inaccurate, the Company may adjust the premium accordingly.
Premium Audit	We will have the right to audit books and records of the Policyholder at its place of business and during its regularly-scheduled business hours, in order to determine the accuracy of premiums paid.

ADMINISTRATIVE PROVSIONS

Premium Changes

We may change premium at the end of any Policy Term with at least 31 days advance notice mailed to the last known address of the Policyholder. We will not increase premium more frequently than annually, unless one of the events described below occurs.

We may change the premium during a Policy Term if any one of the following occurs:

1. the terms of this Policy change;
2. an acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% the number of weeks of covered travel;
3. a change in weeks of travel which would require a change of 10% more or less in the premium;
4. a change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects Our benefit obligations under this Policy;
5. the Policyholder fails to provide sufficient information, as required by Us, to confirm adequacy of premiums currently being paid; or
6. any facultative reinsurance obtained by Us in connection with underwriting or renewal of the Policy is terminated for any reason, or if its cost increases by 10% or more, or Our retention increases by 10% or more.

Any increase or decrease in premium will take effect on the date of the applicable change specified above. A pro rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

Premium Payment

The policyholder is required to remit a flat annual premium payment of USD $12,610.00. Such shall be due and payable in an annual lump sum in accordance with the terms and conditions of this Policy. Payment is due upon receipt of invoice. Premiums are payable at the Home Office of the Insurance Company or to an authorized agent of the Insurance Company.

Policy Effective Date

This Policy takes effect as of 12:01 A.M Eastern Standard Time on the Effective Date, and shall continue in effect as long as the premium is paid on or before the premium due date as herein agreed. Policy years shall be determined from the Policy Anniversary Date as shown on the first page.

ADMINISTRATIVE PROVSIONS

Refund of Premium

We will refund any premium paid for coverage of a specified Covered Activity after the first (1st) anniversary of its Effective Date, if:

1. that Covered Activity is cancelled; and
2. the Policyholder notifies Us in writing at least 7 days before the Covered Activity was scheduled to take place.

No insurance will be in effect for any Covered Person while he participates in, travels to, attends or otherwise is involved in the Covered Activity. If this Policy was issued to insure only the Covered Activity that was cancelled and We were notified as required in 2. above, this Policy will be void from its inception.

Reinstatement

This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid.

Termination of Insurance

The Policyholder may cancel this Policy at any time on or after the first (1st) anniversary of its Effective Date, by sending the Company advanced written notice. The Policy will cancel on the date that the Company receives such notice, or later if the Policyholder so specifies. The Company will return pro rata the unearned portion (if any) of the premiums that were paid.

The Company may terminate this Policy as of any Anniversary Date, by sending the Policyholder at least 31 days advanced written notice. This Policy can also be terminated by the Company if renewal premiums (see premium payment in Administrative Provisions) are not paid by the end of the grace period or within thirty (30) days of their due date, whichever is later. Termination will not affect a claim for a loss which occurs while this Policy is in force.

COVERED - MEDICAL ILLNESS AND INJURY EXPENSES

The term Covered Expenses means the expenses incurred by or on behalf of a covered person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment **of an Injury or a Sickness,** as determined by Cigna. **Any applicable Deductibles or limits are shown in The Schedule.**

Covered Expenses:

1. Charges made by a Hospital, on its own behalf, for Bed and Board, but not more than Hospital's most common semi-private room rate per day outside the United States and not more than the Hospital's average semi-private rate per day of confinement inside the United States.
2. Charges made by a Hospital, on its own behalf, for confinement in an intensive care unit, payable in place of expenses covered in (1) above per day outside the United States and not more than the Hospital's average intensive care unit rate per day inside the United States.
3. Charges made by a Hospital for Necessary Services and Supplies.
4. Charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
5. Charges made by a Free-Standing Surgical Facility, on its own behalf, for medical care and treatment.
6. Charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
7. Charges made by a Physician for professional services.
8. Charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
9. Charges made for anesthetics and their administration, diagnostic x-ray and laboratory examinations, microscopic tests, or any lab tests or analysis made for diagnosis or treatment.
10. Physical therapy and Chiropractic Services.
11. Any care furnished to a newborn child including Hospital nursery expenses prior to discharge from the Hospital.
12. Medical expenses related to non-routine pregnancy care.
13. Charges made for a Dental Emergency up to the benefit amount listed on the medical insurance schedule. A Dental Emergency is defined as a type of medical emergency that involves a dental condition of recent onset and severity, which would lead a prudent layperson possessing an average knowledge of dentistry, to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. This also includes accidental dental treatment of an injury to sound, natural teeth that occurs while on the business trip.
14. Expenses for prescription drugs related to a medical illness or injury that occurs while traveling.
15. Expenses for refilling a prescription drug for necessary medications that was lost while traveling.
16. Expenses related to a pre-existing condition.

EXCLUSIONS - MEDICAL ILLNESS AND INJURY

In addition to any benefit specific exclusion, benefits will not be paid for any Covered Medical Illness or Injury which directly or indirectly, in whole or in part, is caused by or results from any of the following:

1. Injury or Sickness which results from or in the course of an Insured's regular occupation for wage or profit. (This does not apply to a corporate officer, partner or sole proprietor who is not insured under Workers' Compensation Employer's Liability Law or similar law).
2. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
    a. except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
    b. being flown by the Covered Person or in which the Covered Person is a member of the crew;
    c. being used for:
        i. crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
        ii. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
    d. designed for flight above or beyond the earth's atmosphere;
    e. an ultra-light or glider;
    f. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
    g. being used for the purpose of parachuting or skydiving;
3. Injury or Sickness for which an Insured is entitled to benefits under Workers' Compensation Law, Employer's Liability Law or similar law.
4. travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle;
5. participation in any motorized race or contest of speed
6. an accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in Driver's Education Program;
7. travel in any Aircraft owned, leased or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be 'controlled' by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
8. Sickness occurring while the Insured is serving on full-time active duty in the Armed Forces of any country or international authority;
9. Hospital confinement, surgery, treatment, service or supply for which:
    a. the charge is payable or reimbursable by or through a plan or program of any governmental agency;
    b. or charges which would not have been made if the person had no insurance.
10. To the extent that payment is unlawful where the person resides when the expenses are incurred.
11. To the extent that they are more than Maximum Reimbursable Charges.
12. Injury as a result of a commission of a felony.
13. Attempted suicide or intentionally self-inflicted Injury, while sane or insane.
14. Eyeglasses, contact lenses, hearing aids, or examinations for prescription or fitting thereof.
15. Cosmetic or plastic surgery except;
    a. when necessary as a result of an Injury or Sickness occurring while Insured; or
    b. reconstructive surgery when such service is incidental to or follows surgery resulting from Injury or Sickness.
16. Hospital confinement, care or treatment which is not recommended and approved by a Physician.

EXCLUSIONS - MEDICAL ILLNESS AND INJURY

17. Treatment or care of a person by a Physician or Nurse, if the Physician or Nurse is a member of the Insured's immediate family or ordinarily resides with the Insured.
18. Private Duty Nursing.
19. Obesity / Bariatric surgery.
20. Physical examinations unless required because of Injury or Sickness.
21. Dental Expenses unless the result of an accident to sound natural teeth or alleviation of sudden unexpected dental pain, then the benefit is unlimited per calendar year up to the medical maximum.
22. Expenses related to alcoholism, chemical dependency or drug addiction.
23. Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state and or country in which the Covered Accident occurred.
24. Expenses incurred during vacation travel when not in conjunction with a business trip unless specified on the Insurance Schedule.
25. Claim payments which are illegal under applicable law.
26. Medical treatments or procedures deemed not Medically Necessary as determined by the Company.
27. The Covered Persons being Intoxicated. "Intoxicated" means having a blood alcohol level of .08 or higher;
28. Any and all expenses incurred for medical services or treatment in the Insured's country of permanent residence
29. expenses incurred if the original or ancillary purpose of your trip is to obtain medical treatment;
30. Injury or Sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action.
31. Routine maternity treatment.

WAR RISK COVERAGE – MEDICAL ILLNESS AND INJURY

Please refer to the Medical Illness and Injury Schedule to verify this is a covered benefit. If not covered, this section is not applicable.

Benefits are payable for covered accidents which are caused by war or acts of war. This coverage includes loss caused by or resulting from war or acts of war worldwide, but excluding the Insured's country of citizenship. Coverage under this section is subject to the following conditions:

1. The premium for such war risk insurance, the benefits, and the territorial area of coverage provided thereby (or any one or more of them) may be revised by agreement between the Company and the Policyholder at any time, or from time to time as may be necessary to reflect conditions which in the Company's or the Policyholder's opinion, constitute a change in the war risk exposure.

2. Notwithstanding anything to the contrary in the Policy, either the Policyholder or the Company may terminate such war risk insurance upon written notice to the other.

   Termination by the Policyholder shall become effective upon receipt of such written notice mailed to or delivered to the Company's Home Office, or on a later date if specified in such notice.

   Termination by the Company shall become effective upon the date specified by us in such written notice mailed or delivered to the Policyholder at the last address shown in the Company's records. In no event shall it become effective in less than ten (10) days after such notice is mailed or delivered.

   In the event of such termination, the earned premium shall be computed, and the Company will return promptly the unearned portion of any premium paid. Premium adjustment may be made either at the time termination is effective or as soon as practical after termination becomes effective, but payment or tender of unearned premium is not a condition of termination.

3. Any revision or termination of such war risk insurance shall be without prejudice to any claim for loss occurring prior to the effective date of such revision or termination.

Exclusions This benefit does not provide coverage when a Covered Accident occurs:

1. in the United States and its territories and possessions; or
2. in any nation of which the Covered Person is a citizen or a permanent resident.

Other exclusions that apply to this coverage are in the *Exclusions* Section.

MEDICAL CERTIFICATION REQUIREMENTS

Pre-Admission Certification/Continued Stay Review for Hospital Confinement In The United States

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when the Covered Person or their Dependent require treatment in a Hospital:

- as a registered bed patient;
- The Covered Person or their Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, they should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, they should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will not include the first $300 of Hospital charges made for each separate admission to the Hospital:

- unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will be reduced by 50%:

- Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which CH has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan.

CLAIM PROVISIONS - MEDICAL ILLNESS AND INJURY

Notice of an Appeal or a Grievance

Appeal Procedure

The appeal or grievance provision in this policy may be superseded by the law of their state. Please have covered person see their explanation of benefits for the applicable appeal or grievance procedure.

WHEN THERE IS A COMPLAINT OR AN APPEAL

For the purposes of this section, any reference to "covered person", "their", "they" or "Member" also refers to a representative or provider designated by the covered person to act on their behalf, unless otherwise noted. We want the covered person to be completely satisfied with the care they receive. That is why we have established a process for addressing their concerns and solving their problems.

Start with Customer Service

We are here to listen and help. If there is a concern regarding a person, a service, the quality of care, contractual benefits, or rescission of coverage, a covered person can call our toll-free number and explain their concern to one of our Customer Service representatives. They can call us using the Customer Services Toll-Free Number or address that appears on their MBA identification card, explanation of benefits or claim form. We will do our best to resolve the matter on their initial contact. If we need more time to review or investigate their concern, we will get back to them as soon as possible, but in any case within 30 days.

If the covered person is not satisfied with the results of a coverage decision, they can start the appeals procedure.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, a covered person must submit a request for an appeal in writing within 365 days of receipt of a denial notice, to the following address:

Cigna
Attn: Appeals Department
P.O. Box 15800
Wilmington, DE 19850

They should state the reason why they feel their appeal should be approved and include any information supporting their appeal. If they are unable or choose not to write, they may ask to register their appeal by telephone. They can call us at the toll-free number on their MBA identification card, explanation of benefits or claim form.

CLAIM PROVISIONS - MEDICAL ILLNESS AND INJURY

Notice of an Appeal or a Grievance

Level One Appeal

The covered person's appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional in the same or similar specialty as the care under consideration, determined by Cigna's Physician Reviewer.

For level one appeals, we will respond in writing with a decision within fifteen calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a post-service coverage determination. If more time or information is needed to make the determination, we will notify them in writing to request an extension of up to 15 calendar days and to specify additional information needed to complete the review.
The covered person may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize their life, health or ability to regain maximum function or in the opinion of their Physician would cause them severe pain which cannot be managed without the requested services; or (b) their appeal involves non-authorization of an admission or continuing inpatient Hospital stay.

If the covered person requests that their appeal be expedited based on (a) above, they may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to their medical condition. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If the covered person is dissatisfied with our level one appeal decision, they may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

If appeals involve Medical Necessity or clinical appropriateness or experimental treatment medical review will be conducted by a Physician or Dental reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician or Dental reviewer. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was a) not involved in any previous decision related to their appeal, and b) not a subordinate of previous decision makers. Provide all relevant documentation with their second level appeal request. For required pre-service and concurrent care coverage determinations, Cigna's review will be completed within 15 calendar days. For post-service claims, Cigna's review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify them in writing to request an extension of up to 15 calendar days and to specify any additional information needed by Cigna to complete the review. In the event any new or additional information (evidence) is considered, relied upon generated by Cigna in connection with the level-two appeal, Cigna will provide this information to the covered person as soon as possible and sufficiently in advance of the decisions, so that they will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to them as soon as possible and sufficiently in advance of the decision so that they will have an opportunity to respond.

Level Two Appeal cont.

The covered person will be notified in writing of the decision within five days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

The covered person may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize their life, health or ability to regain maximum function or in the opinion of their Physician would cause them severe pain which cannot be managed without the requested services; or (b) their appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review of Medical Appeals - IHCAP

If the covered person is not fully satisfied with the decision of Cigna's level-two appeal review regarding their Medical Necessity or clinical appropriateness issue, they may request that their appeal be referred to an Independent Health Care Appeals Program (IHCAP). The IHCAP is conducted by an Independent Utilization Review Organization (IURO) assigned by the State of Delaware. A decision to use this level of appeal will not affect the claimant's rights to any other benefits under the plan. If the subject of an IHCAP request is appropriate for Arbitration, the Delaware Insurance Department will advise the Participant or his/her authorized representative of the Arbitration procedure.
There is no charge for the covered person to initiate the Independent Review of Medical Appeals (IHCAP) independent review process. Cigna will abide by the decision of the Independent Utilizations Review Organization.

In order to request a referral to an Independent Utilization Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.
To request a review, the covered person must notify the Appeals Coordinator within four months of their receipt of Cigna's level-two appeal review denial. Cigna will then forward the file to the Independent Utilization Review Organization.

The Independent Utilization Review Organization will render an opinion and provide written notice of its decision to the Participant or his/her authorized representative, the carrier and the Delaware Insurance Department within 45 calendar days of its receipt of the appeal. When requested an when the Participant suffers from a condition that poses an imminent, emergency or serious threat or has an emergency medical condition, the review shall be completed within 72 hours of the IURO's receipt of the appeal with immediate notification. The IURO will provide written confirmation of its decision to the Participant or his / her authorized representative, the carrier, and the Delaware Insurance Department within 1 calendar day after the immediate notification.

CLAIM PROVISIONS - MEDICAL ILLNESS AND INJURY

Notice of an Appeal or a Grievance

Claim Appeal to the State of Delaware

The covered person has the right to appeal a claim denial for non-medical reasons to the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services which are in addition to, but do not replace, their right to appeal this decision. They can contact the Delaware Insurance Department for information about an appeal or mediation by calling the Consumer Services Division at (800) 282-8611 or (302) 739-4251.

All requests for mediation or arbitration must be filed within 60 days from the date they receive this notice otherwise this decision will be final.

Independent Review of Administrative Appeals - Arbitration

If the covered person is not fully satisfied with the decision of Cigna's level-two appeal review regarding the denial of claims based on grounds other than medical necessity or appropriateness, they may request that their appeal be referred to Arbitration by submitting the Petition for Arbitration and supporting documentation to the Delaware Insurance Department. A decision to use this level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is a $75 filing fee for them to initiate the Arbitration process; if the arbitrator rules in their favor; Cigna will reimburse them for the $75 filing fee. Cigna will abide by the decision of the Arbitrator. In order to request a referral to Arbitration, certain conditions apply. The reason for the denial must be based on grounds other than medical necessity or appropriateness, such as administrative, eligibility or benefit coverage limits or exclusions.

To request a review, the covered person must submit the Petition for Arbitration and supporting documentation within 60 days of their receipt of Cigna's level-two appeal review denial to the Delaware Insurance Department.

If the subject of an Arbitration request is appropriate for IHCAP review, the Petition for Arbitration will be treated as an IHCAP appeal to determine if the IHCAP appeal is timely filed. The Delaware Insurance Department may summarily dismiss a Petition for Arbitration if it determines the subject is not appropriate for Arbitration or IHCAP or is meritless on its face.

The Arbitrator will render a decision and mail a copy of the decision to the Participant and his/her authorized representative within 45 calendar days of the filing of the Petition. The Arbitrator's decision shall include allowable charges and payments for each service subject to arbitration for a period that will end on the 360th day after the date of the Arbitrator's decision.

CLAIM PROVISIONS - MEDICAL ILLNESS AND INJURY

Notice of an Appeal or a Grievance

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) a statement describing any voluntary appeals procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (6) upon request and free of charge, copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and (7) information about any office or health insurance consumer assistance or ombudsman available to assist in the appeal process. A final notice of adverse determination will include a discussion of the decision.

A covered person also has the right to bring a civil action under Section 502(a) of ERISA if they are not satisfied with the decision on review. They or their plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact their local U.S. Department of Labor office and their State insurance regulatory agency. They may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If their plan is governed by ERISA, they have the right to bring a civil action under Section 502(a) of ERISA if they are not satisfied with the outcome of the Appeals Procedure. In most instances, they may not initiate a legal action against Cigna until they have completed the Level One and Level Two Appeal processes. If their Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action. However, no action will be brought at all unless brought within 3 years after a claim is submitted for U.S. In-Network Services or within three year after proof of a claim required under the Plan for U.S. Out –of – Network and International services.

CLAIM PROVISIONS - MEDICAL ILLNESS AND INJURY

Claim Forms	If direct billing is unavailable, then the prompt filing of any required claim form will result in faster payment of a covered person's claim. They may get the required claim form at www.cignaenvoy.com or from their Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to the servicing Cigna International Service Center. Once treatment is received a claim form must be fully completed, signed, dated, and submitted to Cigna by their physician, along with itemized invoices. Faxing their claim form instead of mailing it will expedite claim processing.
Eligibility Verification Form	This form must be completed along with the employer signing it to verify the dates and location of the approved business trip. This eligibility and benefits data is the basis of every claim Cigna processes and reimburses. If a claim is submitted without the Eligibility Verification Form or an incomplete form, reimbursement may be delayed.

CONDITIONS OF COVERAGE – ACCIDENTAL DEATH AND DISMEMBERMENT

Please refer to the Accidental Death and Dismemberment schedule to verify this is a covered benefit. If not covered, this section is not applicable.

This Section describes the Conditions of Coverage under which benefits provided by this Policy become payable. Any benefits are payable only once, even though more than one Condition of Coverage may apply. Please read these and the *Exclusions* sections in order to understand all of the terms, conditions and limitations of coverage.

BUSINESS TRAVEL COVERAGE

We will pay benefits provided by this Policy, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss caused, directly and independently of all other causes, by a Covered Accident which occurs while the Covered Person is:

1. traveling:
    a. on business of the Policyholder outside the employee home country; and
    b. in the course of the business of the Policyholder; and
    c. on a trip authorized in advance by the Policyholder; and
    d. away from the premises of the Policyholder

Definitions For purposes of this coverage:

Country of Permanent Assignment means the Country where the Covered Person normally works.

Exclusions Coverage for business travel is not provided during any of the following:

1. normal commuting between the Covered Person's home and place of work;
2. travel to another location where the Covered Person is expected to be assigned for more than 180 days;
3. any activity not authorized or organized, or not reimbursable, by the Policyholder;
4. the Covered Person's Personal Deviation, unless shown in the *Schedule of Benefits*;
5. the Covered Person's driving any vehicle or Private Passenger Automobile for pay or hire;

Business Travel Coverage is not in effect while the Covered Person is performing job duties: (a) during work hours; and (b) in a residence work area, which are specified in a written telecommuting agreement between him and his employer.

Other exclusions that apply to this coverage are in the *Exclusions* Section.

EXPOSURE AND DISAPPEARANCE COVERAGE

We will pay benefits provided by this Policy, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss which results, directly and independently of all other causes, from a Covered Accident that causes the Covered Person's unavoidable exposure to the elements following the forced landing, sinking, stranding or wrecking of a vehicle. If the Covered Person disappears and is not found within one year from the date of wrecking, sinking or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that the Covered Person’s death resulted directly and independently of all other causes from a Covered Accident. Travel or trip must have been authorized in advance by the Policyholder.

Exclusions Exclusions that apply to this coverage are in the *Exclusions* Section.

EXCLUSIONS – ACCIDENTAL DEATH AND DISMEMBERMENT

Please refer to the Accidental Death and Dismemberment schedule to verify this is a covered benefit. If not covered, this section is not applicable.

In addition to any benefit-specific exclusion, benefits will not be paid for any Covered Injury or Covered Loss which directly or indirectly, in whole or in part, is caused by or results from any of the following:

1. Dismemberment or Death which results from or in the course of an Insured's regular occupation for wage or profit. (This does not apply to a corporate officer, partner or sole proprietor who is not insured under Workers' Compensation Employer's Liability Law or similar law).
2. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
    a) except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
    b) being flown by the Covered Person or in which the Covered Person is a member of the crew;
    c) being used for:
        i) crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
        ii) any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
    d) designed for flight above or beyond the earth's atmosphere;
    e) an ultra-light or glider;
    f) being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
    g) being used for the purpose of parachuting or skydiving;
3. Dismemberment or Death for which an Insured is entitled to benefits under Workers' Compensation Law, Employer's Liability Law or similar law.
4. travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle;
5. participation in any motorized race or contest of speed
6. an accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in Driver's Education Program;
7. travel in any Aircraft owned, leased or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be 'controlled' by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
8. Dismemberment or death, occurring while the Insured is serving on full-time active duty in the Armed Forces of any country or international authority;
9. To the extent that payment is unlawful where the person resides when the expenses are incurred.
10. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state and or country in which the Covered Accident occurred.
11. Attempted suicide or intentionally self-inflicted Injury, while sane or insane.
12. Expenses incurred during vacation travel when not in conjunction with a business trip.
13. Claim payments which are illegal under applicable law.
14. The Covered Persons being Intoxicated. "Intoxicated" means having a blood alcohol level of .08 or higher;
15. Loss or dismemberment that occurs in the Insured's country of permanent residence
16. Dismemberment or Death caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action.

WAR RISK COVERAGE – ACCIDENTAL DEATH AND DISMEMBERMENT

Please refer to the Accidental Death and Dismemberment schedule to verify this is a covered benefit. If not covered, this section is not applicable.

Benefits are payable for covered accidents which are caused by war or acts of war. This coverage includes loss caused by or resulting from war or acts of war worldwide, but excluding the Insured's country of citizenship. Coverage under this section is subject to the following conditions:

1. The premium for such war risk insurance, the benefits, and the territorial area of coverage provided thereby or any one or more of them may be revised by agreement between the Company and the Policyholder at any time, or from time to time as may be necessary to reflect conditions which in the Company's or the Policyholder's opinion, constitute a change in the war risk exposure.

2. Notwithstanding anything to the contrary in the Policy, either the Policyholder or the Company may terminate such war risk insurance upon written notice to the other.

   Termination by the Policyholder shall become effective upon receipt of such written notice mailed to or delivered to the Company's Home Office, or on a later date if specified in such notice.

   Termination by the Company shall become effective upon the date specified by us in such written notice mailed or delivered to the Policyholder at the last address shown in the Company's records. In no event shall it become effective in less than ten (10) days after such notice is mailed or delivered.

   In the event of such termination, the earned premium shall be computed, and the Company will return promptly the unearned portion of any premium paid. Premium adjustment may be made either at the time termination is effective or as soon as practical after termination becomes effective, but payment or tender of unearned premium is not a condition of termination.

3. Any revision or termination of such war risk insurance shall be without prejudice to any claim for loss occurring prior to the effective date of such revision or termination.

Exclusions This benefit does not provide coverage when a Covered Accident occurs:

1. in the United States and its territories and possessions; or
2. in any nation of which the Covered Person is a citizen or a permanent resident.

Other exclusions that apply to this coverage are in the *Exclusions* Section**.**

CLAIM PROVISIONS - ACCIDENTAL DEATH AND DISMEMBERMENT

Please refer to the Accidental Death and Dismemberment schedule to verify this is a covered benefit. If not covered, this section is not applicable.

Appeal Procedure for Denied Claims

Whenever a claim is denied, your beneficiary has the right to appeal the decision. Your beneficiary or his/her duly authorized representative must make a written request for appeal to the Insurance Company within 60 days from the date your beneficiary received the denial. If he/she does not make this request within that time, he/she will have waived his/her right to appeal.

Once the request has been received by the Insurance Company, a prompt and complete review of the claim must take place. During the review, your beneficiary or his/her duly authorized representative has the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Your beneficiary may also submit issues and comments that he/she feels might affect the outcome of the review.

The Insurance Company has 60 days from the date it receives your beneficiary's request to review the claim and notify your beneficiary of its decision. Under special circumstances, the Insurance Company may require more time to review the claim. If this should happen, the Insurance Company must notify your beneficiary, in writing, that its review period has been extended for an additional 60 days. Once its review is complete, the Insurance Company must notify your beneficiary, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

Beneficiary

The beneficiary, unless the Covered Person specifies otherwise, will be the person he has named as beneficiary of any group life insurance, or if none is in force, of any group accident insurance, provided by the Policyholder.

If there is no named beneficiary or surviving beneficiary, or if the Covered Person dies while benefits are payable to him, We may make direct payment to the first surviving class of the following classes of persons:

1. spouse;
2. child or children
3. parents;
4. siblings;
5. Estate of Covered Person.

Benefit Amount

The Insurance Company will pay the Benefit Amount when it receives due proof that:

- you received an accidental bodily injury while insured for this benefit; and
- as a direct result of that injury, independently of all other causes, you sustained any loss shown in the Table of Losses and Benefits; and
- the loss occurred within 90 days after the date of that injury.

The Benefit Amount for each loss will be your amount of Principal Sum determined from The Schedule multiplied by the percentage shown in the Table of Losses and Benefits for that loss. The maximum that will be paid for all losses resulting from injuries you receive in any one accident will be your amount of Principal Sum.

CLAIM PROVISIONS - ACCIDENTAL DEATH AND DISMEMBERMENT

Please refer to the Accidental Death and Dismemberment schedule to verify this is a covered benefit. If not covered, this section is not applicable.

Claim Form	Written notice of claim must be given to the Insurance Company within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.
Payment of Claims	Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under this Policy, unless otherwise stated, will be payable to the Covered Person or to his estate. If any payee of benefits is a minor or otherwise legally incompetent, we will pay benefits to the person designated as his legal guardian or conservator.

EVACUATION / REPATRIATION BENEFITS

Please refer to the Medical Illness and Injury Schedule to verify this is a covered benefit. If not covered, this section is not applicable.

Notification	Expenses incurred for evacuation or repatriation without the approval and authorization of Cigna and/or its designee will not be Covered Expenses. Only those expenses approved by Cigna will be eligible for coverage and/or reimbursement under the terms of your plan. If the Covered Person suffers a life-threatening/limb-threatening medical condition, and Cigna, and/or its designee, determines that adequate medical facilities are not available locally, Cigna, or its designee, will arrange for an emergency evacuation to the nearest facility capable of providing adequate care.
Emergency Evacuation	The Covered Person must contact Cigna at the phone number indicated on their identification card to begin this process. In making their determinations, Cigna, and/or its designee, will consider the nature of the emergency, their condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions, and distance to be covered. The Covered Person's medical condition must require the accompaniment of a qualified healthcare professional during the entire course of their evacuation to be considered an emergency and requiring emergency evacuation. Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.
Emergency Family Travel Arrangements and Confinement Visitation	If Cigna determines that the Covered Person is expected to require hospitalization in excess of 7 days at the location to which he will be evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual chosen by you. If a Dependent child under age 18 is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the Dependent child is hospitalized.
Return of Dependent Children	If Dependent child(ren) under the age of 18 is left unattended by virtue of the evacuee's absence following a covered evacuation, a one-way economy airfare will be provided to their place of residence or that of an individual chosen by you.

EVACUATION / REPATRIATION BENEFITS

Please refer to the Medical Illness and Injury Schedule to verify this is a covered benefit. If not covered, this section is not applicable.

Repatriation

Following any covered emergency evacuation, Cigna will pay for **one** of the following:

1. if it is deemed Medically Necessary and appropriate by the Cigna medical director, the covered person will be transferred to their permanent residence via a one-way economy airfare or;
2. The covered person will be transferred back to their original work location or the location from which they were evacuated via a one-way economy airfare.

If their transportation needs to be medically supervised a qualified medical attendant will escort them. Additionally, if Cigna and/or its designee, determines a mode of transport other than economy class seating on a commercial aircraft is required, Cigna or its designee will arrange accordingly and such will be covered by Cigna.

Repatriation of Mortal Remains

The costs associated with the transportation of mortal remains from the place of death to the home country will be covered. In addition, assistance will be provided by Cigna or its designee for organizing or obtaining the necessary clearances for the repatriation of mortal remains.

EXCLUSIONS - EVACUATION / REPATRIATION BENEFITS

Please refer to the Medical Illness and Injuury Schedule to verify this is a covered benefit. If not covered, this section is not applicable.

No payment will be made for charges for:

1. services rendered without the authorization or intervention of Cigna or its designee;
2. non emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to you;
3. a condition which would allow for treatment at a future date convenient to you and which does not require emergency evacuation or repatriation;
4. medical care or services scheduled for member or providers convenience which are not considered an emergency
5. expenses incurred if the original or ancillary purpose of your trip is to obtain medical treatment;
6. services provided for which no charge is normally made;
7. expenses incurred while serving in the armed forces of another country;
8. transportation for your vehicle and/or other personal belongings involving intercontinental and/or marine transportation;
9. Service provided other than those indicated in this certificate;
10. injury or sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action;
11. for claim payments that are illegal under applicable law.
12. death caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action; or

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Aircraft	A vehicle which: 1. has a valid certificate of airworthiness; and 2. is being flown by a pilot with a valid license to operate the Aircraft.
Bed and Board	The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.
Coinsurance	The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.
Covered Accident	A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions: 1. occurs while the Covered Person is insured under this Policy; 2. occurs under one of the Conditions of Coverage specified in the Schedule of Benefits; 3. is not contributed to by disease, Sickness, or mental or bodily infirmity; 4. is not otherwise excluded under the terms of this Policy.
Covered Injury	Any bodily harm that result, directly and independently of all other causes, from a Covered Accident.
Covered Person	A Covered Person, as defined in the Insurance Schedule employee class, for whom required premium has been paid when due and for whom coverage under this Policy remains in force.
Deductible	A Deductible are expenses to be paid by you or your Dependent. Deductible amounts are separate from and are in addition to any Coinsurance. Once the Deductible maximum shown in the schedule has been reached, the Covered Person and dependents need not satisfy any further medical deductible for the rest of that year.
Dental Emergency	Dental Emergency is defined as a type of medical emergency that involves a dental condition of recent onset and severity, which would lead a prudent layperson possessing an average knowledge of dentistry, to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. This also includes accidental dental treatment of an injury to sound, natural teeth that occurs while on the business trip.
Dentist	The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Dental Services described in the policy.

GENERAL DEFINITIONS

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
  - less than 26 years old;

  26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap.

A child includes a legally adopted child. It also includes a stepchild who lives with you. If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent.

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by The Insurance Company to be sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit which can be made available to The Insurance Company upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

Employee

An Employee of the Employer who is in one of the Covered Classes.

The term Employee means an employee of the Employer who is currently in Active Service. The term can also mean a contractor or consultant working solely for the employer.

GENERAL DEFINITIONS

Employer

The Policyholder and any entities as shown on the schedule of affiliates, subsidiaries or divisions shown in the employee class covered under this Policy on its effective date or a later date agreed to by Us.

Free-Standing Surgical Facility

The term "Free-Standing Surgical Facility" means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

He, His, Him

Refers to any individual, male or female.

Hospital

An institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense.

Hospital Stay

A confinement in a Hospital, ordered by a Physician, over one or more nights when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a Covered Accident/Injury or Covered Sickness/Illness.

Medically Necessary

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and

rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whoever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Nurse

A licensed graduate registered nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not:

1. the Covered Person;
2. a parent, sibling, spouse or child of either the Covered Person or the Covered Person's spouse;
3. a person living in the Covered Person's household; or
4. a person employed or retained by the Policyholder.

GENERAL DEFINITIONS

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any:

- coinsurance
- deductible

Charges will accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for

- deductibles;
- non-compliance penalties; or
- provider charges in excess of Maximum Reimbursable Charges.

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for:

- non-compliance penalties; and
- provider charges in excess of Maximum Reimbursable Charges.

Personal Deviation (Sojourn)

An activity which:

1. is neither reasonably related to or incidental to the purpose of travel for which coverage is provided by this Policy; and
2. the Covered Person performs before, during or after covered travel.

When coverage is provided during a Personal Deviation, the time period covered is shown in the Conditions of Coverage section of the Schedule of Benefits.

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

1. operating within the scope of his license; and
2. performing a service for which benefits are provided under this plan when performed by a Physician.

and who is not:

3. the Covered Person;
4. a parent, sibling, spouse or child of either the Covered Person or the Covered Person's spouse;
5. a person living in the Covered Person's household;
6. a person employed or retained by the Policyholder; or a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

Policyholder

The entity, named on this Policy's face page, to which we issue this Policy.

Prescription Drug

Prescription Drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

GENERAL DEFINITIONS

Prescription Order	Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who duly licensed to make authorization within the course of such Physician professional practice or each authorized refill thereof.
Private Passenger Automobile	A validly registered, four wheel private passenger car, including Policyholder-owned cars, Automobile campers, motor homes, station wagons, sport utility vehicles, pick-up trucks and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a taxicab, bus, or other public conveyance will not be considered a Private Passenger Automobile.
Review Organization	The term Review Organization refers to an affiliate of The Insurance Company or another entity to which The Insurance Company has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.
Sickness/Illness	A physical illness, including pregnancy. Expenses incurred for routine care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.
Insurance Company, We, Us, Our	Cigna Health and Life Insurance Company (“CH”)

GENERAL PROVISIONS

Certificates

When required by law, The Insurance Company will issue to the Policyholder for delivery to each insured Employee an individual certificate. The Policyholder will be responsible for distributing the certificates to its Employees. The certificate will show the benefits provided under the policy. Nothing in the certificate will change or void the terms of the policy.

Compliance

The Insurance Company's products and services may not be available in all jurisdictions and are expressly excluded from this policy where prohibited by applicable law, including but not limited to, anti-corruption laws and economic sanctions programs administered by the U.S. Treasury Department's Office of Foreign Assets Control.

Conditional Claim Payment

If a covered person incurs expenses for Injuries received in a covered Accident and in our opinion a third party may be liable, we will pay benefits if:

1. the covered person first agrees in writing to refund tile lesser of:
   a. the amount we actually paid for such expenses; or
   b. the amount actually received from the third party for such expenses; and
2. the third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise. However, if the third party's liability is satisfied in an amount less than the benefits payable under the Policy, we will pay the difference.

Consideration

The policy is issued to the Policyholder in consideration of the application and payment of premiums.

Examination of the Policy

This Policy shall be available for inspection by Insureds during normal business hours at Policyholder's office or the office of the administrator.

Execution of Policy

The policy is executed at the Home Office of the Insurance Company. The Post Office address of the Insurance Company is Hartford, Connecticut

Home Country Coverage

The Policyholder certifies that for each individual employee traveler to be covered under this plan, Policyholder maintains or makes available comprehensive medical benefits to such employee in his or her country of permanent assignment in compliance with applicable laws and regulation, or if applicable, such employee maintains government sponsored comprehensive medical benefits. The Policyholder acknowledges that this coverage is not a substitute for such medical benefits in the employee's country of permanent assignment, and that expenses for medical services incurred in an employee's country of permanent assignment are not covered under this plan.

GENERAL PROVISIONS

Insurance Data	The Policyholder will give the Insurance Company all of the data that it needs to calculate the premium and all other data that it may reasonably require. Failure of the Policyholder to give this data will not void or continue an Employee's insurance. The Insurance Company has the right to examine the Policyholder's records relative to these benefits at any reasonable time while the policy is in effect. It also has this right until all rights and obligations under the policy are finally determined.
Legal Actions	No action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with the Insurance Company. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required by the policy.
Multiple International Coverages	The Policyholder certifies that the covered persons are only covered under one international policy offered by the Insurance Company; a covered person cannot have coverage under another international expatriate medical program with the Insurance Company.
Notice of Claim	When the Insurance Company receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after the Insurance Company receives notice of claim, he will be considered to meet the proof of loss requirements of the policy if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.
Physical Examination and Autopsy	At the Company's expense, the Company may have an Insured examined as often as reasonably necessary while a claim is pending. The Company may also request an autopsy in case of death where it is not prohibited by applicable law.
Policy Changes	This Policy (including the endorsements and attached papers) is the entire contract. The application is a part of this Policy. No change in this Policy is valid unless it has been approved by one of the Company's executive officers. This approval must be attached to or endorsed on this Policy. No agent may change this Policy or waive any of its provisions.

GENERAL PROVISIONS

Proof of Loss

Written proof of loss must be given to the Insurance Company within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Records, Examination and Audit

Records Maintained; Examination And Audit - The Policyholder or agent of the Policyholder shall keep records showing the essential facts of each Insured's coverage. During normal business hours and upon five (5) business days advanced notice, the Company may examine these records at any time that this Policy is in force, within three (3) years after this Policy is terminated, or later if claims are still pending.

Recovery of Benefits

The Insurance Company reserves the right to recover from an insured any benefits paid for:

1. injuries received in a covered Accident; and
2. which are covered under:
    a. Workers' Compensation;
    b. Occupational Disease Law, or
    c. any Employer's Liability Insurance.

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

Subrogation

If we have paid benefits to an Insured for Injuries received in a covered Accident, and in our opinion a third party may be liable, we will be subrogated to the extent of such payment and to all of the rights of the Insured regarding the recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Insured agrees to sign papers and do whatever else is necessary to transfer his rights to us. We will exercise such rights on his behalf. He further agrees to furnish us with all relevant information and documents.

Workers Compensation Insurance

This Policy is not in lieu of and does not affect requirements for coverage under any Workers' Compensation law. The Insurance Company reserves the right to coordinate benefits and subrogate against any workers compensations claims.