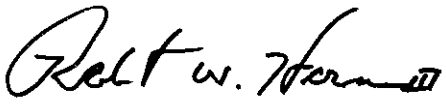
Nationwide Mutual Insurance Company
One Nationwide Plaza
Columbus, Ohio 43215

This Policy of Insurance describes all of the travel insurance benefits, underwritten by Nationwide Mutual Insurance Company and herein referred to as the Company. The insurance benefits vary from program to program. Please refer to the accompanying Confirmation of Coverage. It provides You with specific information about the program You purchased. Please contact the Plan Administrator immediately if You believe that the Confirmation of Coverage is incorrect.

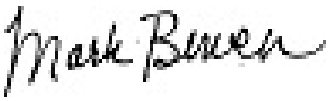
This Policy of Insurance is issued in consideration of the enrollment form and payment of any premium due. All statements in the enrollment forms are representations and not warranties. Only statements contained in a written enrollment form will be used to void insurance, reduce benefits or defend a claim.

NO DIVIDENDS WILL BE PAYABLE UNDER THIS POLICY.

The President and Secretary of Nationwide Mutual Insurance Company witness this Policy.



Secretary



President

TRAVEL PROTECTION CERTIFICATE
EXCESS INSURANCE

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NATIONWIDE MUTUAL INSURANCE COMPANY
TRAVEL PROTECTION INSURANCE POLICY

GENERAL DEFINITIONS

Throughout this document, when capitalized, certain words and phrases are defined as follows:

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

Accidental Injury means Bodily Injury caused by an Accident (of external origin) being the direct and independent cause in the Loss and that 1) requires a physical examination and medical treatment by a Physician and 2) commences while Your coverage is in effect. The injury must be verified by a Physician.

Bodily Contact Sports means any sport where the objective is to physically render an opponent unable to continue with the competition such as boxing and full contact karate.

Bodily Injury means identifiable physical injury that is caused by an Accident and is independent of disease or bodily infirmity.

Common Carrier means any land, sea, and/or air conveyance operating under a valid license for the transportation of passengers for hire. Taxis and limousines are not Common Carriers as defined herein.

Company means Nationwide Mutual Insurance Company.

Confirmation of Coverage means the document that outlines Your benefits and Maximum Benefit amounts.

Covered Expenses means expenses incurred by You that are for Medically Necessary care or treatment; due to Sickness or Bodily Injury; prescribed, performed or ordered by a Physician; Reasonable and Customary Charges incurred while insured under this Policy; and that do not exceed the Maximum Benefit limits shown in the Confirmation of Coverage, under each stated benefit.

Covered Vehicle means any vehicle/boat owned or leased by You and used while on Your Trip that is not used for racing, rentals, dealer services, dealer loaners, taxi, limousine, shuttle, delivery, hauling, towing, road repair service, construction service, snow removal, or as a public livery vehicle, or any other commercial use.

Dependent Child(ren) means Your child (or children), including an unmarried child, stepchild, legally adopted child or foster child who is: (1) less than age nineteen (19) and primarily dependent on You for support and maintenance; or (2) who is at least age nineteen (19) but less than age twenty-six (26).

Economy Fare means the lowest published rate for a round trip economy ticket.

Effective Date means 12:01 A.M. local time, at Your location, on the day after the required premium for such coverage is received by the Company or its authorized representative.

Extreme Sports means an athletic pursuit that involves a high degree of danger or risk.

Family Member means Your legal or common law spouse, parent, legal guardian, step-parent, grandparent, parents-in-law, grandchild, natural or adopted child, step-child, children-in-law, brother, sister, step-brother, step-sister, brother-in-law, sister-in-law, aunt, uncle, niece or nephew.

Hospital means a facility that:
(a) holds a valid license if it is required by the law;
(b) operates primarily for the care and treatment of sick or injured persons as in-patients;
(c) has a staff of one or more Physicians available at all times;
(d) provides twenty-four (24) hour nursing service and has at least one registered professional nurse on duty or call;
(e) has organized diagnostic and surgical facilities, either on the premises or in facilities available to the hospital on a pre-arranged basis; and
(f) is not, except incidentally, a clinic, nursing home, rest home, drug or physical rehabilitation facility or convalescent home for the aged, or similar institution.

Insured means the person who enrolled for coverage and whose premium was paid under this Policy.

Loss means Bodily Injury, Sickness or damage sustained by You, while coverage is in effect, in consequence of happening of one or more of the occurrences against which the Company has undertaken to indemnify You.

Maximum Benefit means the largest total amount that the Company will pay under any one benefit for You, as shown on the Confirmation of Coverage.

Medically Necessary means a service or supply that: (a) is recommended by the attending Physician; (b) is appropriate and consistent with the diagnosis in accord with accepted standards of community practice; (c) could not have been omitted without adversely affecting Your condition or quality of medical care; (d) is delivered at the most appropriate level of care and not primarily for the sake of convenience; and (e) is not considered experimental unless coverage for experimental services or supplies is required by law.

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

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

Physician means a licensed practitioner of medical, surgical or dental services acting within the scope of his/her license. The treating Physician may not be You, a Traveling Companion or a Family Member.

Policy means this document including the application and any endorsements, riders or amendments that will attach during the period of coverage.

Reasonable and Customary Charges means charges commonly used by Physicians in the locality in which care is furnished.

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

Scheduled Return Date means the date on which You are originally scheduled to return to the point of origin or to a different final destination.

Sickness means an illness or disease of the body that: 1) requires a physical examination and medical treatment by a Physician and 2) commences while Your coverage is in effect. An illness or disease of the body that begins prior to the Effective Date of coverage is not a Sickness as defined herein and is not covered by this Policy unless it suddenly worsens or becomes acute after the Effective Date.

Traveling Companion means a person who has coordinated Travel Arrangements or vacation plans with You, intends to travel with You during the Trip. Note, a group or tour leader is not considered a Traveling Companion unless You are sharing room accommodations with the group or tour leader.

Travel Arrangements means: (a) transportation; (b) accommodations; and (c) other specified services arranged by the Travel Supplier for the Trip.

Travel Supplier means tour operator, Cruise line, airline, hotel, travel agency, etc. who has made the land, air and/or sea arrangements.

Trip means a trip or class of trips as described on the Confirmation of Coverage.

Unforeseen means not anticipated or expected and occurring after the Effective Date of Your coverage.

You or Your refers to the Insured.

GENERAL PROVISIONS

The following provisions apply to all coverages:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

CONTROLLING LAW - Any part of this Policy that conflicts with the state law where the Policy is issued is changed to meet the minimum requirements of that law.

MISREPRESENTATION AND FRAUD – Your coverage shall be void if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance concerning this Policy or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing.

You must fully cooperate in the event the Company determines that an investigation of any claim is warranted.

SUBROGATION - To the extent the Company pays for a Loss suffered by You, the Company will take over the rights and remedies You had relating to the Loss. This is known as subrogation. You must help the Company to preserve its rights against those responsible for the Loss. This may involve signing any papers and taking any other steps the Company may reasonably require. If the Company takes over Your rights, You must sign an appropriate subrogation form supplied by the Company.

ASSIGNMENT - This Policy is not assignable, whether by operation of law or otherwise, but benefits may be assigned.

WHEN YOUR COVERAGE BEGINS - Provided:
(a) coverage has been elected; and
(b) the required premium has been paid.

All coverage will begin at 12:01 A.M. local time at Your location on the Scheduled Departure Date.

WHEN YOUR COVERAGE ENDS - Your coverage will end at 11:59 P.M. local time on the date that is the earliest of the following:

(a) the date the Policy is terminated.
(b) the Scheduled Return Date as stated on the travel tickets;
(c) the date You return to Your origination point if prior to the Scheduled Return Date;
(d) the date You leave or change the Trip (unless due to Unforeseen and unavoidable circumstances covered by the Policy);
(e) when You are less than one hundred fifty (150) miles from Your primary residence.

The following provisions apply to all benefits:

NOTICE OF CLAIM - Written notice of claim must be given by the claimant (either You or someone acting for You) to the Company or its designated representative within twenty (20) days after a covered Loss first begins or as soon as reasonably possible. Notice should include Your name, the Travel Supplier's name and the Plan number. Notice should be sent to the Company's administrative office, or to the Company's designated representative.

PROOF OF LOSS - The claimant must send the Company, or its designated representative, Proof of Loss within ninety (90) days after a covered Loss occurs or as soon as reasonably possible. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS - Benefits payable under this Policy for any Loss other than Loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written Proof of such Loss. Subject to due written Proof of Loss, all accrued indemnities for Loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability, will be paid immediately upon receipt of due written proof.

All claims shall be paid within thirty (30) days following receipt by the Company of due Proof of Loss. Failure to pay within such period shall entitle the claimant to interest at the rate of six (6) percent per annum from the thirtieth (30^{th}) day after receipt of such Proof of Loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. You or Your assignee shall be notified by the Company or designated representative of any known failure to provide sufficient documentation for a due Proof of Loss within thirty (30) days after receipt of the claim. Any required interest payments shall be made within thirty (30) days after the payment.

EMERGENCY EVACUATION

The Company will pay benefits for Covered Expenses incurred, up to the Maximum Benefit shown on the Confirmation of Coverage, if an Accidental Injury or Sickness commencing during the course of the Trip results in Your necessary Emergency Evacuation. All Maximum Benefits referred to in this benefit are aggregate amounts for all Losses sustained by You. An Emergency Evacuation must be ordered by a Physician who certifies that the severity of Your Accidental Injury or Sickness warrants Your Emergency Evacuation.

Emergency Evacuation means:

(a) Your medical condition warrants immediate Transportation from the hospital where You are first taken when injured or sick to the Hospital of Your choice where appropriate medical treatment can be obtained; If elected, Transportation to Your hospital of choice will begin when You are determined to be stable enough for Transportation. Once You arrive at the hospital of choice, coverage for all benefits under this Certificated ends.
(b) after being treated at a local Hospital, Your medical condition warrants Transportation to where You reside, to obtain further medical treatment or to recover; or
(c) both (a) and (b).

Covered Expenses are reasonable and customary expenses for necessary Transportation, related medical services and medical supplies incurred in connection with Your Emergency Evacuation. All Transportation arrangements made for evacuating You must be by the most direct and economical route possible. Expenses for Transportation must be:

(a) recommended by the attending Physician;
(b) required by the standard regulations of the conveyance transporting You; and
(c) authorized in advance by the Company or its authorized representative.

Transportation of Traveling Companion or Dependent Children: If You are in the Hospital for more than two (2) days following a covered Emergency Evacuation, the Company will return Your Traveling Companion and/or unattended Dependent Children accompanying You on the scheduled Trip, to their home.

Transportation to Join You: If You are in a Hospital alone for more than seven (7) consecutive days, or if the attending Physician certifies that due to Your Accidental Injury or Sickness, You will be required to stay in the Hospital for more than seven (7) consecutive days, upon request the Company will bring a person, chosen by You, for a single visit to and from Your bedside.

If You suffer an Accidental Injury or Sickness while on the Trip that results in Hospitalization and the attending Physician advises You against driving Your Covered Vehicle home, the Company will pay the charges imposed up to the Maximum Benefit shown on the Confirmation of Coverage to return the unattended vehicle to Your primary residence. This coverage is only afforded to non-commercial vehicles.

Transportation services are provided if authorized in advance by the assistance provider, and are limited to necessary Economy Fares less the value of applied credit from unused travel tickets, if applicable.

Transportation means any Common Carrier, or other land, water or air conveyance, required for an Emergency Evacuation and includes air ambulances, land ambulances and private motor vehicles.

The Company will not cover any expenses provided by another party at no cost to You or already included within the cost of the Trip.

REPATRIATION OF REMAINS

The Company will pay the reasonable Covered Expenses incurred to return Your body to Your primary residence if You die during the Trip. This will not exceed the Maximum Benefit shown on the Confirmation of Coverage. This benefit is provided if authorized in advance by the assistance provider.

Covered Expenses include, but are not limited to, expenses for embalming, cremation, casket for transport and transportation.

LIMITATIONS AND EXCLUSIONS

The following exclusions apply to Emergency Evacuation and Repatriation of Remains:

Loss caused by or resulting from:

1. suicide, attempted suicide or any intentionally self-inflicted injury while sane or insane;
2. intentionally self-inflicted injuries;
3. war, invasion, acts of foreign enemies, hostilities between nations (whether declared or not), civil war;
4. participation in any military maneuver or training exercise;

5. piloting or learning to pilot or acting as a member of the crew of any aircraft;
6. mental or emotional disorders, unless Hospitalized;
7. participation as a professional in athletics;
8. being under the influence of drugs or intoxicants, unless prescribed and used in accordance with the instructions provided by a Physician;
9. commission or the attempt to commit a dishonest, fraudulent or criminal act;
10. participating in Bodily Contact Sports (football, wrestling, ice hockey, rugby, lacrosse, boxing, full contact karate, hurling and rodeo); skydiving; hang-gliding; Parachuting, Mountaineering; any race; bungee cord jumping; speed contest (speed contest shall not include any of the regatta races;) scuba diving unless accompanied by a dive master or if the depth exceeds fifty (50) feet; or deep sea diving; spelunking or caving; heliskiing; extreme skiing; Extreme Sports;
11. pregnancy and childbirth (except for complications of pregnancy) except if Hospitalized;
12. traveling for the purpose of securing medical treatment;
13. services not shown as covered;
14. directly or indirectly, the actual, alleged or threatened discharge, dispersal, seepage, migration, escape, release or exposure to any hazardous biological, chemical, nuclear radioactive material, gas, matter or contamination;
15. care or treatment that is not Medically Necessary;
16. canyoning or canyoneering (traveling in canyons using a variety of techniques that may include walking, scrambling, climbing, jumping, abseiling and/or swimming;
17. Accidental Injury or Sickness when traveling against the advice of a Physician.

Nationwide®

Nationwide Mutual Insurance Company
One Nationwide Plaza
Columbus, Ohio 43215

This Policy of Insurance describes all of the travel insurance benefits, underwritten by Nationwide Mutual Insurance Company and herein referred to as the Company. The insurance benefits vary from program to program. Please refer to the accompanying Confirmation of Coverage. It provides You with specific information about the program You purchased. Please contact the Plan Administrator immediately if You believe that the Confirmation of Coverage is incorrect.

This Policy of Insurance is issued in consideration of the enrollment form and payment of any premium due. All statements in the enrollment forms are representations and not warranties. Only statements contained in a written enrollment form will be used to void insurance, reduce benefits or defend a claim.

All premium is non-refundable after a ten (10) day review period from the date of purchase in the event You have not incurred any claims during that time. In the event the premium paid for coverage is less than the required premium for coverage, benefits will be paid in direct proportion of the actual amount paid to the required premium due.

NO DIVIDENDS WILL BE PAYABLE UNDER THIS POLICY.

The President and Secretary of Nationwide Mutual Insurance Company witness this Policy.

Secretary

President

TRAVEL PROTECTION CERTIFICATE
EXCESS INSURANCE

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NATIONWIDE MUTUAL INSURANCE COMPANY
TRAVEL PROTECTION INSURANCE POLICY

GENERAL DEFINITIONS

Throughout this document, when capitalized, certain words and phrases are defined as follows:

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

Accidental Injury means Bodily Injury caused by an Accident (of external origin) being the direct and independent cause in the Loss and that 1) requires a physical examination and medical treatment by a Physician and 2) commences while Your coverage is in effect. The injury must be verified by a Physician.

Bodily Injury means identifiable physical injury that is caused by an Accident and is independent of disease or bodily infirmity.

Common Carrier means any land, sea, and/or air conveyance operating under a valid license for the transportation of passengers for hire. Taxis and limousines are not Common Carriers as defined herein.

Company means Nationwide Mutual Insurance Company.

Confirmation of Coverage means the document that outlines Your benefits and Maximum Benefit amounts.

Effective Date means 12:01 A.M. local time, at Your location, on the day after the required premium for such coverage is received by the Company or its authorized representative.

Family Member means Your legal or common law spouse, parent, legal guardian, step-parent, grandparent, parents-in-law, grandchild, natural or adopted child, step-child, children-in-law, brother, sister, step-brother, step-sister, brother-in-law, sister-in-law, aunt, uncle, niece or nephew.

Hospital means a facility that:
(a) holds a valid license if it is required by the law;
(b) operates primarily for the care and treatment of sick or injured persons as in-patients;
(c) has a staff of one or more Physicians available at all times;
(d) provides twenty-four (24) hour nursing service and has at least one registered professional nurse on duty or call;
(e) has organized diagnostic and surgical facilities, either on the premises or in facilities available to the hospital on a pre-arranged basis; and
(f) is not, except incidentally, a clinic, nursing home, rest home, drug or physical rehabilitation facility or convalescent home for the aged, or similar institution.

Insured means the person who enrolled for coverage and whose premium was paid under this Policy.

Loss means Bodily Injury, Sickness or damage sustained by You, while coverage is in effect, in consequence of happening of one or more of the occurrences against which the Company has undertaken to indemnify You.

Maximum Benefit means the largest total amount that the Company will pay under any one benefit for You, as shown on the Confirmation of Coverage.

Medically Necessary means a service or supply that: (a) is recommended by the attending Physician; (b) is appropriate and consistent with the diagnosis in accord with accepted standards of community practice; (c) could not have been omitted without adversely affecting Your condition or quality of medical care; (d) is delivered at the most appropriate level of care and not primarily for the sake of convenience; and (e) is not considered experimental unless coverage for experimental services or supplies is required by law.

Other Insurance means any one of the following types of policies or plans that provides benefits for Hospital confinement, medical expenses for you at the time of Loss on Your Effective Date of coverage, and such policy or plan requires You to pay any applicable Deductible and/or portion of coinsurance: individual, group or blanket insurance plans; HMO's, PPO's, POS's, EPO's, employer organization plans, employee benefit organizational plans, or other arrangements of benefits for persons of a group. Insurance does not include Medicare or Medicaid.

Physician means a licensed practitioner of medical, surgical or dental services acting within the scope of his/her license. The treating Physician may not be You, a Traveling Companion or a Family Member.

Policy means this document including the application and any endorsements, riders or amendments that will attach during the period of coverage.

Pre-Existing Condition means an illness, disease, or other condition during the sixty (60) day period immediately prior to the Effective Date for which You, a Traveling Companion, a Family Member booked to travel with You: 1) exhibited symptoms which would have caused one to seek care or treatment; or 2) received a recommendation for a test, examination, or medical treatment or 3) took or received a prescription for drugs or medicine. Item (3) of this definition does not apply to a condition which is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the sixty (60) day period before the Effective Date.

Reasonable and Customary Charges means charges commonly used by Physicians in the locality in which care is furnished.

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

Scheduled Return Date means the date on which You are originally scheduled to return to the point of origin or to a different final destination.

Sickness means an illness or disease of the body that: 1) requires a physical examination and medical treatment by a Physician and 2) commences while Your coverage is in effect. An illness or disease of the body that begins prior to the Effective Date of coverage is not a Sickness as defined herein and is not covered by this Policy unless it suddenly worsens or becomes acute after the Effective Date.

Sound Natural Teeth means teeth that are whole or properly restored and are without impairment, periodontal or other conditions and are not in need of the treatment provided for any reason other than an Accidental Injury. For purposes of this Policy, teeth previously restored with a crown, inlay, onlay, or porcelain restoration or treated by endodontics, except amalgam or composite resin fillings, are not considered Sound Natural Teeth.

Traveling Companion means a person who has coordinated Travel Arrangements or vacation plans with You, intends to travel with You during the Trip. Note, a group or tour leader is not considered a Traveling Companion unless You are sharing room accommodations with the group or tour leader.

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

Travel Supplier means tour operator, Cruise line, airline, hotel, etc. who has made the land, air and/or sea arrangements.

Trip means a trip or class of trips as described on the Confirmation of Coverage.

You or Your refers to the Insured.

GENERAL PROVISIONS

The following provisions apply to all coverages:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

CONTROLLING LAW - Any part of this Policy that conflicts with the state law where the Policy is issued is changed to meet the minimum requirements of that law.

MISREPRESENTATION AND FRAUD – Your coverage shall be void if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance concerning this Policy or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing.

You must fully cooperate in the event the Company determines that an investigation of any claim is warranted.

ASSIGNMENT - This Policy is not assignable, whether by operation of law or otherwise, but benefits may be assigned.

WHEN YOUR COVERAGE BEGINS - Provided:
(a) coverage has been elected; and
(b) the required premium has been paid.

All coverage will begin at 12:01 A.M. local time at Your location on the Scheduled Departure Date.

WHEN YOUR COVERAGE ENDS - Your coverage will end at 11:59 P.M. local time on the date that is the earliest of the following:

(a) the date the Policy is terminated.
(b) the Scheduled Return Date as stated on the travel tickets;
(c) the date You return to Your origination point if prior to the Scheduled Return Date;
(d) the date You leave or change the Trip (unless due to Unforeseen and unavoidable circumstances covered by the Policy);
(e) when You are less than one hundred fifty (150) miles from Your primary residence.

EXCESS INSURANCE LIMITATION - The insurance provided by this Certificate shall be in excess of all other valid and collectible insurance or indemnity. If at the time of the occurrence of any Loss there is other valid and collectible insurance or indemnity in place, the Company shall be liable only for the excess of the amount of Loss, over the amount of such Other Insurance or indemnity, and applicable Deductible.

PAYMENT OF CLAIMS - The Company, or its designated representative, will pay a claim after receipt of acceptable Proof of Loss.

Benefits for Loss of life are payable to Your 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 claims will be paid to You. In the event You are a minor, incompetent or otherwise unable to give a valid release for the claim, the Company may make arrangement to pay claims to Your legal guardian, committee or other qualified representative.
Any payment made in good faith will discharge the Company's liability to the extent of the claim.

The applicable benefit amount will be reduced by the amount of benefits, if any, previously paid by Other Insurance policies. In no event will the Company reimburse You for an amount greater than the amount paid by You.

NOTICE OF CLAIM - Written notice of claim must be given by the claimant (either You or someone acting for You) to the Company or its designated representative within twenty (20) days after a covered Loss first begins or as soon as reasonably possible. Notice should include Your name and the Plan number. Notice should be sent to the Company’s administrative office, or to the Company's designated representative.

PROOF OF LOSS - The claimant must send the Company, or its designated representative, Proof of Loss within ninety (90) days after a covered Loss occurs or as soon as reasonably possible. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

PHYSICAL EXAMINATION AND AUTOPSY - The Company, or its designated representative, at its own expense, have the right to have You examined as often as reasonable necessary while a claim is pending. The Company, or its designated representative, also has the right to have an autopsy made unless prohibited by law.

TIME OF PAYMENT OF CLAIMS - Benefits payable under this Policy for any Loss other than Loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written Proof of such Loss. Subject to due

written Proof of Loss, all accrued indemnities for Loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability, will be paid immediately upon receipt of due written proof.

All claims shall be paid within thirty (30) days following receipt by the Company of due Proof of Loss. Failure to pay within such period shall entitle the claimant to interest at the rate of six (6) percent per annum from the thirtieth (30^{th}) day after receipt of such Proof of Loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. You or Your assignee shall be notified by the Company or designated representative of any known failure to provide sufficient documentation for a due Proof of Loss within thirty (30) days after receipt of the claim. Any required interest payments shall be made within thirty (30) days after the payment.

EMERGENCY ACCIDENT MEDICAL EXPENSE

The Company will reimburse benefits up to the Maximum Benefit shown on the Confirmation of Coverage, if You incur Covered Medical Expenses for Emergency Treatment of an Accidental Injury that occurs during the Trip.

Emergency Treatment means necessary medical treatment that must be performed during the Trip due to the serious and acute nature of the Accidental Injury.

Covered Medical Expenses are expenses incurred for necessary services and supplies: (a) listed below; and (b) ordered or prescribed by the attending Physician as Medically Necessary for treatment, that are limited to:

(a) the services of a Physician;
(b) charges for Hospital confinement and use of operating rooms;
(c) charges for anesthetics (including administration); x-ray examinations or treatments, and laboratory tests;
(d) ambulance service; and
(e) drugs, medicines and therapeutic services.

The Company will not pay benefits in excess of the Reasonable and Customary Charges. The Company will not cover any expenses provided by another party at no cost to You, or already included within the cost of the Trip.

The Company will pay benefits up to the Maximum Benefit shown on the Confirmation of Coverage for dental Emergency Treatment for Accidental Injury to Sound Natural Teeth. Both the Accidental Injury and the dental Emergency Treatment must occur during the Trip.

If You are Hospitalized due to an Accidental Injury that first occurred during the course of the Trip beyond the Scheduled Return Date, coverage under this benefit will be extended until You are released from the Hospital or until Maximum Benefits under this Policy have been paid.

EMERGENCY SICKNESS MEDICAL EXPENSE

The Company will reimburse benefits up to the Maximum Benefit shown on the Confirmation of Coverage, if You incur Covered Medical Expenses as a result of Emergency Treatment of a Sickness that first manifests itself during the Trip.

Emergency Treatment means necessary medical treatment that must be performed during the Trip due to the serious and acute nature of the Sickness.

Covered Medical Expenses are expenses incurred for necessary services and supplies: (a) listed below; and (b) ordered or prescribed by the attending Physician as Medically Necessary for treatment, that are limited to:

(a) the services of a Physician;
(b) charges for Hospital confinement and use of operating rooms;
(c) charge for anesthetics (including administration); x-ray examinations or treatments, and laboratory tests;
(d) ambulance service; and
(e) drugs, medicines and therapeutic services.

The Company will not pay benefits in excess of the Reasonable and Customary Charges. The Company will not cover any expenses provided by another party at no cost to You, or already included within the cost of the Trip.

If You are Hospitalized due to a Sickness that first occurred during the course of the Trip beyond the Scheduled Return Date, coverage under this benefit will be extended until You are released from the Hospital or until Maximum Benefits under this Policy have been paid.

LIMITATIONS AND EXCLUSIONS

The following exclusions apply to Emergency Accident Medical Expense and Emergency Sickness Medical Expense:

Loss caused by or resulting from:

1. Pre-Existing Conditions, as defined in the Definitions section (except Emergency Evacuation and Repatriation of Remains);
2. suicide, attempted suicide or any intentionally self-inflicted injury while sane or insane (unless results in the death of a non-traveling Family Member);
3. intentionally self-inflicted injuries;
4. war, invasion, acts of foreign enemies, hostilities between nations (whether declared or not), civil war;
5. participation in any military maneuver or training exercise;
6. piloting or learning to pilot or acting as a member of the crew of any aircraft;
7. mental or emotional disorders, unless Hospitalized;
8. participation as a professional in athletics;
9. being under the influence of drugs or intoxicants, unless prescribed and used in accordance with the instructions provided by a Physician;
10. commission or the attempt to commit a dishonest, fraudulent or criminal act;
11. participating in Bodily Contact Sports (football, wrestling, ice hockey, rugby, lacrosse, boxing, full contact karate, hurling and rodeo); skydiving; hang-gliding; Parachuting; Mountaineering; any motorized race; bungee cord jumping; speed contest (speed contest shall not include any of the regatta races) scuba diving (unless accompanied by a dive master or if the depth exceeds fifty (50) feet); deep sea diving; spelunking or caving; heliskiing; extreme skiing; Extreme Sports;
12. dental treatment except as a result of an injury to Sound Natural Teeth within twelve (12) months of the injury;
13. any non-emergency treatment or surgery, routine physical examinations, hearing aids, eye glasses or contact lenses;
14. pregnancy and childbirth (except for complications of pregnancy); except if Hospitalized;
15. traveling for the purpose of securing medical treatment;
16. services not shown as covered;
17. directly or indirectly, the actual, alleged or threatened discharge, dispersal, seepage, migration, escape, release or exposure to any hazardous biological, chemical, nuclear radioactive material, gas, matter or contamination;
18. care or treatment that is not Medically Necessary;
19. canyoning or canyoneering (traveling in canyons using a variety of techniques that may include walking, scrambling, climbing, jumping, abseiling and/or swimming;
20. care of treatment that is payable under any Other Insurance policy;
21. Accidental Injury or Sickness when traveling against the advice of a Physician.

COORDINATION OF BENEFITS

Applicability
The Coordination of Benefits ("COB") provision applies to This Plan when You have health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan.

The benefits of This Plan:
(a) will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
(b) may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described further in the section entitled Effect on the Benefits of This Plan.

Definitions
Plan is a form of written on an expense incurred basis that provides benefits or services for, or because of, medical or dental care or treatment. "Plan" includes:
(a) group insurance and group remittance subscriber contracts;
(b) uninsured arrangements of group coverage;
(c) group coverage through HMO's and other prepayment, group practice and individual practice Plans; and
(d) blanket contracts, except blanket school accident coverages or a similar group when the Policyholder pays the premium.

"Plan" does not include individual or family:
(a) insurance contracts;
(b) direct payment subscriber contracts;
(c) coverage through HMO's; or
(d) coverage under other prepayment, group practice and individual practice Plans.

This Plan is the parts of this blanket contract that provide benefits for health care expenses on an expense incurred basis.

Primary Plan is one whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if either:
(a) the Plan either has no order of benefit determination rules, or it has rules that differ from those in the contract; or
(b) all Plans that cover the person use the same order of benefits determination rules as in this contract, and under those rules the Plan determines its benefits first.

Secondary Plan is one that is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this contract decide the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan that, under the rules of this contract, has its benefits determined before those of that Secondary Plan.

Allowable Expense is the necessary, reasonable, and customary item of expense for health care; when the item of expense is covered at least in part under any of the Plans involved.

The difference between the cost of a private Hospital room and a semi-private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice.

When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered both an Allowable Expense and a benefit paid.

Claim is a request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of:
(a) services (including supplies);
(b) payment for all or a portion of the expenses incurred; or
(c) a combination of (a) and (b).

Claim Determination Period is the period of time that must not be less than twelve (12) consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine:
(a) whether Other Insurance exists; and

(b) how much each Plan will pay or provide.

For the purposes of this contract, Claim Determination Period is the period of time beginning with the Effective Date of coverage and ending twelve (12) consecutive months following the date of Loss or longer as may be determined by the Proof of Loss provision.

Order of Benefit Determination Rules
When This Plan is a Primary Plan, its benefits are determined before those of any other Plan and without considering another Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of any other Plan only when, under these rules, it is secondary to that other Plan .

When there is a basis for a Claim under This Plan and another Plan, This Plan is a Secondary Plan that has its benefits determined after those of the other Plan, unless:
(a) the other Plan has rules coordinating its benefits with those of This Plan; and
(b) both those rules and This Plan's rules, as described below, require that This Plan's benefits be determined before those of the other Plan.

Rules
This Plan determines its order of benefits using the first of the following rules which applies:
(a) Nondependent/Dependent Rule. The benefits of the Plan that covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan that covers the person as a dependent.
(b) Longer/Shorter Length of Coverage Rule. The benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan that covered that person for the shorter time.

To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within twenty-four (24) hours after the first ended. Thus, the start of a new Plan does not include: (a) a change in the amount or scope of a Plan's benefits; (b) a change in the entity that pays, provides or administers the Plan's benefits; or (c) a change from one type of Plan to another. The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

Effect on the Benefits of This Plan When it is Secondary
The benefits of This Plan will be reduced when it is a Secondary Plan so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than the total Allowable Expenses, not otherwise paid that were incurred during the Claim Determination Period by the person for whom the Claim is made. As each Claim is submitted, This Plan determines its obligation to pay for Allowable Expenses based on all Claims that were submitted up to that point in time during the Claim Determination Period.

Right to Receive and Release Needed Information
Certain facts are needed to apply these COB rules. The Company has the right to decide which facts are needed. The Company may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Company any facts we need to pay the Claim.

Facility of Payment
A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable monetary value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by the Company is more than the Company should have paid under this COB provision, the Company may recover the excess from one or more of: (a) the persons we have paid or for whom we have paid; (b) insurance companies; or (c) other organizations.

Non-complying Plans

This Plan may coordinate its benefits with a Plan that is excess or always secondary or that uses order of benefit determination rules that are inconsistent with those of This Plan (non-complying Plan) on the following basis:

(a) If This Plan is the Primary Plan, This Plan will pay its benefits on a primary basis;

(b) if This Plan is the Secondary Plan, This Plan will pay its benefits first, but the amount of the benefits payable will be determined as if This Plan were the Secondary Plan. In this situation, our payment will be the limit of This Plan's liability; and

(c) if the non-complying Plan does not provide the information needed by This Plan to determine its benefits within thirty (30) days after it is requested to do so, the Company will assume that the benefits of the non-complying Plan are identical to This Plan and will pay benefits accordingly. However, the Company will adjust any payments made based on this assumption whenever information becomes available as to the actual benefits of the non-complying Plan.

STATE MANDATED LANGUAGE
GROUP CERTIFICATE NSHTC 2500 A&H P&C SPLIT

Massachusetts

Under the section entitled **GENERAL PROVISIONS**, the **DISAGREEMENT OVER SIZE OF LOSS** provision is deleted in its entirety and replaced with the following:

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the Loss, upon mutual agreement, either You or the Company can make a written request for an appraisal. After the request, You and the Company will each select their own competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount of the Loss. If they do not agree, they will select an arbitrator. Any figure agreed to by two (2) of the three (3) (the appraisers and the arbitrator) will be non-binding. Such appraisal will be voluntary, will be by mutual consent by all parties, and will be non-binding. The appraiser selected by You will be paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process.

NSHTC 2200 MA PC

Oklahoma – A&H

The following **FRAUD STATEMENT** and **UNDERWRITING** notices are added:

FRAUD STATEMENT
Warning: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for proceeds of an insurance certificate containing any false, incomplete or misleading information is guilty of felony.

UNDERWRITTEN BY
This certificate is underwritten by:
Nationwide Mutual Insurance Company
1 Nationwide Plaza
Columbus, OH 43215-2220

The following is added to the **TEN-DAY FREE LOOK** provision:

If We do not return any premiums or money's paid within thirty (30) days from the date of cancellation, We will pay interest on the proceeds.

On page 1, the second full paragraph is deleted in its entirety and replaced with the following:

This Certificate of Insurance is issued in consideration of the enrollment form and payment of any premium due. All statements in the enrollment forms are representations and not warranties. Only statements contained in a written enrollment form will be used to render this Certificate voidable, reduce benefits or defend a claim.

Under the section entitled **GENERAL DEFINITIONS**, the definition of **Family Member** is deleted in its entirety and replaced with the following:

Family Member means Your or a Traveling Companion's legal or common law spouse, parent, legal guardian, step-parent, grandparent, parents-in-law, grandchild, natural or adopted child from the moment of placement with You, step-child, children-in-law, brother, sister, step-brother, step-sister, brother-in-law, sister-in-law, aunt, uncle, niece, nephew, Business Partner or Domestic Partner who reside in the United States, Canada or Mexico.

Under the section entitled **GENERAL DEFINITIONS**, the definition of **Pre-Existing Condition** is deleted in its entirety and replaced with the following:

Pre-Existing Condition means any injury, sickness or condition of You, an Insured's Traveling Companion or an Insured's Family Member booked to travel with him or her for which within the sixty (60) day period prior to the effective date under the Group Policy (a) first manifested itself or exhibited symptoms which would have caused one to seek diagnosis, care or treatment; (b) required taking prescribed drugs or medicine, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or (c) required medical treatment or treatment was recommended by a Physician.

Such an Injury or Sickness will continue to be a Pre-Existing Condition until the expiration of 12 consecutive months, beginning with the effective date of coverage.

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

Under the section entitled **GENERAL PROVISIONS**, the **CONTROLLING LAW** provision is deleted in its entirety and replaced with the following:

CONTROLLING LAW - Any part of this certificate that conflicts with the state law of Oklahoma is changed to meet the minimum requirements of that law. Where the policy and certificate differ, the certificate will govern.

Under the section entitled **GENERAL PROVISIONS**, the **MISREPRESENTATION AND FRAUD** provision is deleted in its entirety and replaced with the following:

MISREPRESENTATION AND FRAUD – Your coverage shall be voidable if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance concerning this Certificate or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing.

You must fully cooperate in the event the Company determines that an investigation of any claim is warranted.

Under the section entitled **GENERAL PROVISIONS**, the **WHEN YOUR COVERAGE ENDS** provisions are revised as follows:

The references to 11:59 pm are amended to read 12:01 am.

Under the section entitled **GENERAL PROVISIONS**, the **EXCESS INSURANCE LIMITATION** provision does not apply to medical or dental benefits. The reference to “Excess Insurance” does not apply to Emergency Accident Medical Expense or Emergency Sickness Medical Expense.

Under the section entitled **GENERAL PROVISIONS**, the **PROOF OF LOSS** provision is deleted in its entirety and replaced with the following:

PROOF OF LOSS - The claimant must send the Company, or its designated representative, Proof of Loss within ninety (90) days after a covered Loss occurs or as soon as reasonably possible. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Under the section entitled **LIMITATIONS AND EXCLUSIONS**, exclusion 4 is deleted in its entirety and replaced with the following:

4. war or any act of war, whether war is declared or not while serving in military service or any auxiliary thereto;

Under the section entitled **LIMITATIONS AND EXCLUSIONS**, exclusion 18 is deleted in its entirety.

In the section entitled **COORDINATION OF BENEFITS**, the definition of **Plan** is deleted in its entirety and replaced with the following:

Plan means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by:
(a) group, blanket or franchise insurance coverage,
(b) service plan contracts, group practice, individual practice and other prepayment coverage,
(c) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans, and
(d) any coverage under governmental programs, and any coverage required or provided by any statute.

(e) all group or group subscriber contracts as well as such group-type contracts as are not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization or group. Group-type contracts include individual policy forms that are utilized and whether or not the group-type coverage is designated as "franchise" or "blanket" or in some other fashion.
(f) both group and individual automobile "no fault" contracts but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis may be included.

Plan does not include:
(a) Individual or family policies, or individual or family subscriber contracts, except as provided in items (v) and (vi) above.
(b) Individually underwritten and issued contracts which provide a contractual right to renewal regardless of membership in or connection with any particular organization or group shall not be considered group type contracts, irrespective of the mode or channel of premium payment and regardless of any reduction in premium the covered person may receive by virtue of such method of premium collection.
(c) group or group-type hospital indemnity benefits (written on a non-expense incurred basis) of $30 per day or less unless they are characterized as reimbursement type benefits but are designed to administer so as to give the insured the right to elect indemnity type benefits, in lieu of such reimbursement type benefits, at the time of claim. In any event, the amount of group and group-type hospital indemnity benefits which exceed $30 per day may be construed as being included under the definition of Plan.
(d) School accident type coverages, written on either an individual, blanket, group or franchise basis should not be taken in to consideration in coordination of benefits. In this context, school accident type coverages are defined to mean coverage covering grammar school, middle school, and high school students for accidents only, including athletic injuries, either on a 24 hour basis or "to and from school" for which the parent pays the entire premium.

In the section entitled **COORDINATION OF BENEFITS**, the **Right of Recovery** provision is deleted in its entirety and replaced with the following:

Whenever payments which should have been made under this Plan in accordance with this section have been made under any other Plans, the insurer shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this section, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the insurer shall be fully discharged from liability under this Plan.

NSHTC 2200 OK AH

Oklahoma – P&C

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

Under the section entitled **GENERAL PROVISIONS,** the **CONTROLLING LAW** provision is deleted in its entirety and replaced with the following:

CONTROLLING LAW - Any part of this Certificate that conflicts with the state law of Oklahoma is changed to meet the minimum requirements of that law.

Under the section entitled **GENERAL PROVISIONS**, the **MISREPRESENTATION AND FRAUD** provision is deleted in its entirety and replaced with the following:

MISREPRESENTATION AND FRAUD – Your coverage shall be voidable if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance concerning this Certificate or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing.

You must fully cooperate in the event the Company determines that an investigation of any claim is warranted.

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, or makes any claim for proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Under the section entitled **GENERAL PROVISIONS,** the **WHEN YOUR COVERAGE ENDS** provision is revised as follows:

All references to 11:59 PM are amended to read 12:01 AM.

Under the section entitled **LIMITATIONS AND EXCLUSIONS**, exclusion 4 is deleted in its entirety and replaced with the following:

4. War or any act of war, whether war is declared or not while serving in military service or any auxiliary thereto:

Under the section entitled **LIMITATIONS AND EXCLUSIONS**, exclusions 8, 11, 18 and 23 are deleted in their entirety.

Under the section entitled **LIMITATIONS AND EXCLUSIONS**, subsections which read, **"The following exclusions apply to Baggage/Personal Effects and Baggage Delay"** the exclusions related to war are deleted in their entirety and replaced with the following:

War or any act of war, whether war is declared or not while serving in military service or any auxiliary thereto:

NSHTC 2200 OK PC

Tennessee

The following is added to page 1 of the Certificate:

This Certificate is underwritten by:
Nationwide Mutual Insurance Company
1 Nationwide Plaza
Columbus, OH 43215
(614) 854-3375

The Certificate includes an **EXCESS INSURANCE LIMITATION**. The benefits in this Certificate are secondary to any valid and collectible insurance.

The Free-Look provision on page 1 is deleted in its entirety and replaced with the following:

All premium is non-refundable after a ten (10) day review period from the date of purchase in the event You have not incurred any claims during that time. In the event the premium paid for coverage is less than the required premium for coverage, benefits will be paid in direct proportion of the actual amount paid to the required premium due.

Under the Section entitled **GENERAL DEFINITIONS**, the definition of **Accident** is deleted in its entirety and replaced with the following:

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

Under the Section entitled **GENERAL DEFINITIONS**, the definition of **Dependent Child(ren)** is deleted in its entirety and replaced with the following:

Dependent Child(ren) means Your child (or children), including an unmarried child, stepchild, legally adopted child or foster child who is: (1) less than age twenty-four (24) and primarily dependent on You for support and maintenance; or (2) who is at least age twenty-four (24) and who regularly attends an accredited school or college; and who is primarily dependent on You for support and maintenance.

Under the Section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

Under the Section entitled **GENERAL PROVISIONS**, the following is added to the **NOTICE OF CLAIM** provision:

A claim form will be sent to You within 15 days of Our receipt of Your Notice of Claim. If such form is not furnished within fifteen (15) days after the giving of such notice, You shall be deemed to have complied with the requirements of this Certificate as to Proof of Loss upon submitting, within the time fixed in the Certificate for filing Proofs of Loss, written proof covering the occurrence, the character and the extent of the Loss for which claim is made.

The fully completed claim form must be returned to the claims administrator with:
1. Written Proof of Loss.
2. Any other documentation that the Company may reasonably request.

All these required items, including the claim form, must be postmarked within 90 days or as soon as reasonably possible after the date of Loss. Otherwise, the claim may be denied.

Under the Section entitled **GENERAL PROVISIONS**, the **PROOF OF LOSS** provisions are deleted in their entirety and replaced with the following:

You must send the Company or the claims administrator, Proof of Loss within 180 days or as soon as reasonably possible after a covered Loss occurs. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

The first paragraph of **EMERGENCY SICKNESS MEDICAL EXPENSE** is deleted in its entirety and replaced with the following:

The Company will reimburse benefits up to the Maximum Benefit shown on the Confirmation of Coverage, if You incur Covered Medical Expenses as a result of Emergency Treatment of a Sickness that manifests itself during the Trip.

NSHTC 2200 TN

Texas – A&H

Under the section entitled **GENERAL DEFINITIONS**, the definition of **HOSPITAL** is deleted in its entirety and replaced with the following:

Hospital means a facility that:
(a) is licensed as a hospital and operated pursuant to law; and
(b) is primarily engaged in providing or operating (either on its premises or in facilities available to the hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed physicians), medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
(c) provides 24-hour nursing service by or under the supervision of a registered graduate professional nurse (RN); and
(d) is an institution which maintains and operates a minimum of five beds; and
(e) has x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
(f) maintains permanent medical history records.

Hospital does not include:
(a) the federal government or any agency thereof for the treatment of members or ex-members of the armed forces; or
(b) convalescent homes, convalescent facilities, rest facilities, or nursing facilities; or
(c) home or facilities primarily for the aged, drug addicts, alcoholics, those primarily affording custodial care, educational care or those primarily affording care for mental and nervous disorders.

Under the section entitled **GENERAL DEFINITIONS**, the definition of **Pre-Existing Condition** is deleted in its entirety and replaced with the following:

Pre-Existing Condition means an illness, disease, or other condition during the sixty (60) day period immediately prior to the Effective Date for which You, a Traveling Companion or a Family Member booked to travel with You: 1) received medical advice or treatment for a disease or physical condition; or 2) took or received a prescription for drugs or medicine. Item (2) of this definition does not apply to a condition that is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the sixty (60) day period before the Effective Date.

Under the section entitled **GENERAL PROVISIONS**, the **MISREPRESENTATION AND FRAUD** provision is deleted in its entirety and replaced with the following:

MISREPRESENTATION AND FRAUD – Your coverage shall be void if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance in writing within the two-year period after the Effective Date of coverage concerning this Certificate or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing.

You must fully cooperate in the event the Company determines that an investigation of any claim is warranted.

Under the section entitled **GENERAL PROVISIONS**, the following is added to the **WHEN YOUR COVERAGE ENDS** provision:

Coverage will not end solely because a person becomes an elected official in Texas.

Under the section entitled **GENERAL PROVISIONS**, the **PROOF OF LOSS** provision is deleted in its entirety and replaced with the following:

PROOF OF LOSS - You have 91 days from the date of your loss to submit your claim to us, except as otherwise provided by law.

Within 15 business days after we receive of notice of a claim we will:

- acknowledge receipt of the claim (If acknowledgement of the claim is not made, in writing, we will make a record of the date, means, and content of the acknowledgement.)
- commence any investigation of the claim; and
- request from you all items, statements, and forms that We reasonably believe, at that time, will be required from you. Additional requests may be made if during the investigation of the claim such additional requests are necessary.

We will notify you in writing of the acceptance or rejection of a claim no later than 15 business days after we receive all Proof of Loss required by us. If we reject the claim, we will tell you the reasons for the rejection. If we are unable to accept or reject the claim within 15 business days after we receive all Proof of Loss required, we will notify you within the 15 business-day period and tell you why we need additional time to investigate the claim. If we require additional time to investigate your claim, we will notify you if we accept or reject the claim no later than 45 business days after we request additional time to investigate the claim.

Except as otherwise provided, if we delay payment of a claim for more than 60 business days following receipt of all required Proof of Loss, we will pay the amount of the claim plus 18 percent interest per year along with reasonable attorney fees. If a lawsuit is filed, such attorney fees shall be taxed as part of the costs in the case.

Under the section entitled **GENERAL PROVISIONS**, the following **ENTIRE CONTRACT** provision is added:

ENTIRE CONTRACT - This certificate, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. A change in this certificate is not valid until the change is approved by an executive officer of the insurer and unless the approval is endorsed on or attached to the certificate. An agent does not have authority to change this certificate or to waive any of its provisions.

Under the section entitled **LIMITATIONS AND EXCLUSIONS**, exclusion 7 is deleted in its entirety and replaced with the following:

7. mental, emotional or functional disorder without demonstrable organic disease;

Under the section entitled **COORDINATION OF BENEFITS**, the provision entitled **Rules** is amended to read:

Rules
The general order of benefits is as follows:
The Primary Plan must pay or provide its benefits as if the Secondary Plan or plans did not exist. A plan that does not include a coordination of benefits provision may not take the benefits of another plan into account when it determines its benefits. There is one exception. A contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided.

A Secondary Plan may take the benefits of another plan into account only when, under this subchapter, it is secondary to that other plan.

In determining the order of benefit, We must use the first of the following rules which applies.

1. With respect to categories of non-dependent as related to dependent coverage, the benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent. There is one exception. If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.
2. With respect to a dependent child whose parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time. As used in this paragraph, the word “birthday " refers only to month and day in a calendar year, not the year in which the person was born. If the plan does not have the rule based upon the parent's birthday, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon gender of the parent will determine the order of benefits.
3. With respect to a dependent child whose parents are separated or divorced, where two or more plans cover the child, benefits for the child are determined in this order:
    a) first, the plan of the parent with custody of the child;
    b) then, the plan of the spouse of the parent with the custody of the child; and
    c) finally, the plan of the parent not having custody of the child.
    d) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
    e) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph 2. above of this subsection.
4. With respect to active as related to inactive employees, the benefits shall be determined in the following order. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
5. With respect to continuation coverage, if a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
    a) first, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
    b) second, the benefits under the continuation coverage.
    c) If the other plan does not have the rule described in subparagraphs (A) and (B) of this paragraph, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
6. Where none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter term. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. The start of a new plan does not include:
    a) a change in the amount or scope of a plan's benefits;
    b) a change in the entity which pays, provides or administers the plan's benefits; or
    c) a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

NSHTC 2200 TX AH

Texas – P&C

Under the section entitled **GENERAL DEFINITIONS**, the definition of **Business Day** is added as follows:

Business Day means all days except Saturday, Sunday, or holidays recognized by Texas.

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than two (2) years from the date the cause of action first accrues.

Under the section entitled **GENERAL PROVISIONS**, the following is added to the **WHEN YOUR COVERAGE ENDS** provision:

Coverage will not end solely because a person becomes an elected official in Texas.

Under the section entitled **GENERAL PROVISIONS**, the **PROOF OF LOSS** provision is deleted in its entirety and replaced with the following:

PROOF OF LOSS - You have 91 days from the date of your Loss to submit your claim to us, except as otherwise provided by law.

Within 15 Business Days after we receive of notice of a claim we will:

- acknowledge receipt of the claim (If acknowledgement of the claim is not made, in writing, we will make a record of the date, means, and content of the acknowledgement.)
- commence any investigation of the claim; and
- request from you all items, statements, and forms that We reasonably believe, at that time, will be required from you. Additional requests may be made if during the investigation of the claim such additional requests are necessary.

We will notify you in writing of the acceptance or rejection of a claim no later than 15 business days after we receive all Proof of Loss required by us. If we reject the claim, we will tell you the reasons for the rejection. If we are unable to accept or reject the claim within 15 business days after we receive all Proof of Loss required, we will notify you within the 15 business-day period and tell you why we need additional time to investigate the claim. If we require additional time to investigate your claim, we will notify you if we accept or reject the claim no later than 45 business days after we request additional time to investigate the claim.

Except as otherwise provided, if we delay payment of a claim for more than 60 business days following receipt of all required Proof of Loss, we will pay the amount of the claim plus 18 percent interest per year along with reasonable attorney fees. If a lawsuit is filed, such attorney fees shall be taxed as part of the costs in the case.

Under the section entitled **GENERAL PROVISIONS**, the **DISAGREEMENT OVER SIZE OF LOSS** provision is deleted in its entirety and replaced with the following:

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the Loss, within thirty (30) days of the date of the disagreement either You or the Company can make a written demand for an appraisal. Within fifteen (15) days after the demand, You and the Company will each select their own competent appraiser. After examining the facts, each of the two appraisers will give an opinion within fifteen (15) days of their selection on the amount of the Loss. If they do not agree, they will select an arbitrator within fifteen (15) days from the date of their opinion. Any figure agreed to by two (2) of the three (3) (the appraisers and the arbitrator) will be binding. The appraiser selected by You will be paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process.

NSHTC 2200 TX PC

IMPORTANT NOTICE TO ALL TEXAS POLICYHOLDERS

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Nationwide Mutual Insurance Company's toll-free telephone number for information or to make a complaint at

1-800-525-8669

You may also write to Nationwide Mutual Insurance Company at:

Nationwide Mutual Insurance Company
One Nationwide Plaza
Columbus, OH 43215
Mail Code 4-06-101

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance

333 Guadalupe
Austin, TX 78701
FAX # (512) 475-1771
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Nationwide Mutual Insurance Company para informacion o para someter una queja al

1-800-525-8669

Usted tanbien puede escribir a Nationwide Mutual Insurance Company:

Nationwide Mutual Insurance Company
One Nationwide Plaza
Columbus, OH 43215
Mail Code 4-06-101

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

333 Guadalupe
Austin, TX 78701
FAX # (512) 475-1771
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (Texas Department of Insurance)

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto

NATIONWIDE PRIVACY STATEMENT

FACTS	WHAT DOES NATIONWIDE DO WITH YOUR PERSONAL INFORMATION?

Why?	Financial companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Social Security number, government issued identification, and contact information • Policy, account, and contract information • Credit reports and other consumer reports
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Nationwide chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Nationwide share?	Can you limit this sharing?
For our everyday business purposes— such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes— to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes— information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes— information about your creditworthiness	Yes	Yes
For our affiliates to market to you	Yes	Yes
For non affiliates to market to you	Yes	Yes

To limit our sharing	Call us toll free at 1-866-280-1809 and our menu will prompt you through your choices. If you have previously opted out, your preference remains on file and you do not need to opt out again. Please have your account or policy number handy when you call. **Please note**: If you are a *new* customer, we can begin sharing your information 30 days from the date we sent this notice. When you are *no longer* our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.
Questions?	1-800-753-1000

Who we are	
Who is providing this notice?	Nationwide Mutual Insurance Company
What we do	
How does Nationwide protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal and state law. These measures include computer safeguards and secured files and buildings. We limit access to your information to those who need it to do their job.
How does Nationwide collect my personal information?	We collect your personal information, for example, when you: Apply for insurance Make a payment or file a claim Conduct business with us We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.

Why can't I limit all sharing?	Federal and state law gives you the right to limit only: Sharing for affiliates' everyday business purposes—information about your creditworthiness; Affiliates from using your information to market to you; and Sharing for non affiliates to market to you. State laws and individual companies may give you additional rights to limit sharing. See below for more information.
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. These companies include Nationwide Life Insurance Company, Nationwide Bank, and Nationwide Property and Casualty Insurance Company. Visit nationwide.com for a list of affiliated companies.
Non affiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you.

Other important information

California Residents: We currently do not share information we collect about you with affiliated or nonaffiliated companies for their marketing purposes. Therefore, you do not need to opt out.

Nevada Residents: You may request to be placed on our internal Do Not Call list. Send an email with your phone number to privacy@nationwide.com. You may request a copy of our telemarketing practices. For more on this Nevada law, contact Bureau of Consumer Protection, Office of the Nevada Attorney General, 555 E. Washington St., Suite 3900, Las Vegas, NV 89101; Phone number: 1-702-486-3132; email: BCPINFO@ag.state.nv.us.

Vermont Residents: For Vermont customers only. We will not share your personal information for marketing purposes with the Nationwide family of companies or third parties without your authorization, except as permitted by law.

AZ, CA, CT, GA, IL, ME, MA, MT, NV, NJ, NM, NC, ND, OH, OR, and VA Residents: When we refer to "Information" we mean information we collect during an insurance transaction (not including medical record information). We will not use your medical information for marketing purposes without your consent. We share personal information with non-affiliates without your prior authorization as permitted or required by law. They may use it to investigate fraud, respond to court orders, and conduct actuarial studies. We share it with insurance regulatory authorities and law enforcement. We share it with consumer reporting agencies. They may retain it or disclose it to other companies with which you do business. These other companies use and disclose it to others as permitted by law. We obtain reports prepared by an insurance-support organization. The insurance-support organization keeps copies and discloses them to others. You have a right to access and correct your Information as described below.

Accessing your information

You can ask us for a copy of your personal information. Please send your request to the address below and have your signature notarized. This is for your protection so we may prove your identity. Please include your name, address, and policy number. You can change your personal information at Nationwide.com or by calling your agent. We can't change information that other companies, like credit agencies, provide to us. You'll need to ask them to change it.

Co-ordinated Benefit Plans
Attn: Privacy Officer
P.O. Box 26222
Tampa, FL 33623

Travel Assistance Services are provided by an independent organization and not by the Company. There may be times when circumstances beyond Travel MedEvac's Assistance Provider's control hinder their endeavors to provide travel assistance services. They will, however, make all reasonable efforts to provide travel assistance services and help you resolve your emergency situation.

Assistance Services

This document provides details on Assistance Services provided and does not amend, alter or extend the coverage afforded by the certificate of insurance. Electronic summary and digital documents and/or custom links have been provided to the Plan Holder. Although not required to carry for services, we do recommend you carry your confirmation summary and other forms of identification at all times for convenience should you need to contact us if you are admitted to a hospital with a serious or critical injury or illness which may necessitate an evacuation.

Customer Service

If you have questions about the services provided, you can view many of the frequently asked questions by visiting our website www.travelmedevac.com or by reviewing an overview of coverages and services offered by Travel MedEvac. Your specific travel protection plan you elected to purchase, including insurance benefits and services, will be listed in your Confirmation of Coverage. If you have additional questions on your plan, please contact the agent or representative who sold you the plan, or contact Travel MedEvac Customer Service at the following:

Customer Service Contact

Email: info@travelmedevac.com

Phone: 1-888-963-4933

Outside the USA or Canada Dial:

1-602-344-9225

24/7 Emergency Medical Assistance Services

If you are hospitalized with a serious or critical injury or illness, please call us at the following:

1-888-963-4933

Outside the USA or Canada Dial:

1-602-344-9225

Press "2" at the Prompt

Whether you are the insured or calling on behalf of the insured, please have the following information available.

- Full Name of Insured Patient
- Current Condition of Insured Patient
- Name of the Hospital and Location
- Hospital Phone Number(s)
- Name of Physician(s)/Hospital Administrator
- Policy Number

If You Are Filing A Reimbursement Claim For Emergency Medical Coverage

If you are provided emergency medical services at a hospital and seeking reimbursement for out of pocket costs, please utilize the claims form available at https://www.travelmedevac.com/claims-services/ where additional instructions are available.

You may mail your form and information to:
Co-ordinated Benefit Plans, LLC
On Behalf of Travel MedEvac
P.O. Box 26222
Tampa, FL 33623
Or E-mail your information to: Team1@cbpinsure.com

IMPORTANT: To facilitate prompt claims settlement, You will be asked to provide proof of Your loss. Therefore, be sure to obtain the following: Detailed medical statements from treating physicians where and when the accident or Sickness occurred as well as receipts for medical services and supplies. You will also be asked to provide proof of payment.

Assistance Services Are Provided Through Travel MedEvac and Its Assistance Provider

ASSISTANCE SERVICES WHEN HOSPITALIZED

The following details on steps you should take if you are hospitalized with a serious or critical condition more than 150 miles away from your home.

If you, a family member or companion has an emergency, please have medical treatment sought at the local hospital immediately. If not admitted to the hospital and seeking reimbursement for qualified emergency medical expenses, please follow the instructions on the claim page of our website www.travelmedevac.com/claims-services/ to submit a claim to be reimbursed for eligible expenses. If admitted to the hospital for a serious or critical injury or illness, please call us and you will be connected with our Assistance Provider, available 365 days a year, 24 hours a day. Our Assistance Provider will work with you, your family or companion along with the attending Physician(s) and medical facility personnel to review your coverage and arrange payment of qualified medical services direct to the hospital if necessary. If it is determined a medical evacuation may be needed, whether the evacuation is to be carried out via a commercial aircraft or a private, medically equipped aircraft, a Medical Assessment, including Medical Records and other information regarding your health condition, will be needed prior to a medical evacuation being approved and arranged.

MEDICAL EVACUATION ARRANGEMENTS

Your enrollment in the Plan provides you access to medically warranted hospital-to-hospital evacuation transportation arranged by Travel MedEvac's Assistance Provider and their Medical Evacuation Providers according to the terms, conditions, and limitations set forth in the certificate of insurance.

All arrangements for transportation or assistance services under your plan must be made through Travel MedEvac's Assistance Provider and their Medical Evacuation providers, which when available, use highly accredited EURAMI or CAMTS certified air ambulance companies through our extensive network of providers. Any arrangements made by Plan Holder for medical evacuation services with an alternate air ambulance company or Assistance Provider will not be reimbursed for any charges or expenses incurred without our prior authorized written and notarized approval.

You agree to promptly notify, or have your representative promptly notify us for request of medical evacuation transportation if you believe it may be needed, specifying the nature of the injury or illness. Due to the nature of the services, a reasonable period of time is required to properly initiate a medical evacuation transportation, and you agree that diligence is necessary to properly accommodate a medical emergency. You also agree to provide notice of request at the earliest possible time, so we can secure a comprehensive medical assessment and to allow proper time to determine eligibility and prepare the medical evacuation transportation. Failure to contact us for the medical evacuation transportation in a timely manner may result in a denial or delay of services.

To facilitate providing the services, you hereby authorize us, Assistance Provider and any Medical Evacuation Provider utilized to disclose or discuss your medical information with any physician, hospital, medical attendant, or others regarding your physical condition including but not limited to medical records and diagnostic images and test results. This authorization shall remain valid until such time as you or your authorized representative revokes it in writing.

You also authorize us, the Assistance Provider and their network of air ambulance providers and any medical personnel or medical facility involved in the medical transport process to review your medical records, diagnostic images, and test results. The sending physician, receiving physician, and the Assistance Provider's, Medical Personnel must agree that the Plan Holder requires continued inpatient hospitalization, meets the criteria for an air medical transport and the Plan holder is medically stable for an approved transport to a qualifying medical facility. The medical evacuation transportation will not be provided until such time as we have obtained a completed medical assessment, the transport meets other applicable terms and there is confirmed admission to the receiving medical facility. Admission to the receiving hospital typically requires medical and financial acceptance. Repatriation from outside one's home country requires proper documentation, such as a passport, visa, etc. to clear customs and is the responsibility of the Plan Holder. A Plan Holder and/or companion may be denied medical evacuation transportation if they are unable to provide such documentation or are denied admission to their home hospital of choice.

You further authorize the Assistance Provider's Medical Evacuation Provider's medical personnel to perform procedures and provide treatment as they deem necessary, both prior to and during the course of your medical evacuation transportation. We do not provide or control the provision of medical services to Plan Holders. Our performance of our obligations under the Travel MedEvac's plan assistance services is ministerial in nature and shall not constitute any undertaking to render medical services, to assume or guarantee the result of medical services provided to Plan Holders, or to guarantee that the medical services performed by others will be rendered in accordance with generally accepted standards or procedures. The parties understand and agree that the rendering of medical services to a Plan Holder and the results thereof are solely within the control of the Medical Evacuation Provider's medical personnel. Travel MedEvac is not liable for any malpractice by the Medical Evacuation Provider, their contracted network of air ambulance companies, or other healthcare providers, and the Plan Holder agrees to hold Travel MedEvac and its assigns harmless for said services.

GENERAL EXCLUSIONS AND LIMITATIONS ON ASSISTANCE SERVICES

Medical evacuation transportation is subject to limitations on the operation of aircraft imposed by mechanical issues, weather, regulations and restrictions imposed by the United States Federal Aviation Administration or comparable aviation administration authority of any other jurisdiction in which a medical facility or Plan Holder may be located, and other conditions beyond the control of Travel MedEvac or the Assistance Provider and their Medical Evacuation Providers.

A Plan Holder weighing in excess of three hundred (300) pounds or having other physical characteristics may limit the ability to place a Plan Holder into an aircraft due to size limitations of a fixed wing air ambulance aircraft and may be prohibited from transport.

The Assistance Provider and its Medical Evacuation Provider will manage the logistics of all air medical transports, including the possibility of using an alternate medical evacuation transportation provider that is part of their extensive worldwide network of accredited air ambulance companies should the need arise. Medical evacuation transportation from airports in some countries is restricted or closed to private aircraft, including air ambulance aircraft, from dusk until dawn which may delay an aircraft from reaching a Plan Holder.

Your plan provides medical evacuation transportation only through the use of ground ambulances and aircraft assigned by Travel MedEvac's Assistance Providers and their Medical Evacuation Providers. Your plan does not reimburse or otherwise allow for transportation arranged by the Plan Holder or provided through any other means (e.g., helicopter). Since your plan requires you to arrange any medical transports or services through our Assistance Provider, Plan Holders will not be reimbursed for expenses they incur on their own.

Both the sending and receiving medical facility must be reasonably accessible by ground ambulance to transport the Plan Holder to and from an airfield capable of accommodating medical aircraft transportation assigned by us. Air medical transport from remote areas or islands to a location with an airfield accessible to our primary provider's medical aircraft is not provided. Costs of evacuation from these remote areas to a location where we can provide service are the responsibility of the Plan Holder.

Due to limited medical and laboratory facilities on cruise ships, if a Plan Holder becomes ill or injured on a cruise ship, in all cases we will require a Plan Holder to be admitted to a hospital on-shore for a thorough medical assessment before a possible Medical evacuation transportation to another medical facility can be considered.

Aircraft and personnel cannot be sent into countries where the U.S. State Department or other governmental regulatory agency has issued travel restrictions, or to areas where civil aviation has been suspended or restricted, due to a natural disaster, civil unrest, an outbreak of illness/disease or any other cause. Various countries throughout the world may pose travel and/or medical restrictions, at any time, that prevent a transport. Your plan is subject to exclusion in these areas, as well as for any medical evacuation transportation that would be in violation of any Federal Aviation Administration rules or regulations, or comparable aviation administration authority, or Presidential orders restricting air travel for any jurisdiction you may be traveling. A Plan Holder diagnosed with or suspected of having tuberculosis or other chronic pathogens or infectious disease as defined and classified by the Center for Disease Control and Prevention, the National Institutes of Health, or comparable administration authority, may be prohibited from transport due to travel and other governmental restrictions.

The patient, and an accompanying passenger(s) if the medical condition and space allows, are limited to one small carry-on bag each due to limited space available on the medical aircraft.

ADDITIONAL DISCLAIMER AND LIMITATIONS ON LIABILITY

The Plan Holder acknowledges that medical evacuation transportation is arranged through our Primary Medical Evacuation Provider and their extensive network of air ambulance companies, although the ground ambulance and aircraft is equipped with personnel and equipment to sustain and preserve the life of a patient while in transit, a Plan Holder's condition may deteriorate during the transport to the point of death or irreparable harm. The Plan Holder understands and assumes this risk, and therefore agrees that Travel MedEvac, plan underwriter Nationwide® , our Assistance Provider and their Medical Evacuation Providers or other outside contractors, including their shareholders, officers, managers, employees, agents, affiliates, distributors, predecessors, successors, and assigns, shall not be responsible to any person, including but not limited to the Plan Holder or the Plan Holder's estate, survivors, agents, assigns, or representatives, for the Plan Holder's death or deterioration of the Plan Holder's condition.

Travel MedEvac and its underwriters, managers, employees, agents, affiliates, successors, and assigns shall not be liable for any harm or damages relating to or resulting from services provided by our Assistance Provider, their Medical Evacuation Providers or other outside contractors. Neither Travel MedEvac nor its underwriters, managers, employees, agents, affiliates, distributors, successors, or assigns shall be liable to any person for the death, disability, or injury of the Plan Holder or any other person accompanying the Plan Holder unless the injury is determined by a court to be solely caused by the gross negligence or willful misconduct of Travel MedEvac. We shall not be liable for delay or failure to perform under the plan if such delay or failure is caused by the unavailability of a ground ambulance or aircraft, government restrictions, mechanical failure, acts of god, fire, flood, strike, labor dispute, riot, insurrection, war, or any other cause beyond the control of Travel MedEvac, our Assistance Provider and their extensive network of highly accredited worldwide Medical Evacuation Providers, or other outside contractors.

GENERAL PROVISIONS

Except as otherwise set forth in this certificate of insurance, the assistance provided is provided on an "as is" and "as available" basis. Travel MedEvac and its managers, employees, agents, affiliates, distributors, successors, and assigns expressly disclaim all warranties of any kind, whether express or implied. The Plan Holder, individually and on behalf of the Plan Holder's estate, and the Plan Holder's survivors, agents, assigns, and representatives, expressly understand and agree that Travel MedEvac and its Assistance Provider, Medical Evacuation Provider,, managers, employees, agents, affiliates, distributors, successors, and assigns shall not be liable to the Plan Holder or the Plan Holder's estate, survivors, agents, representatives, or assigns, or the general public, for any direct, indirect, incidental, special, consequential, punitive, or exemplary damages relating to or arising out of the plan or the services to be provided hereunder. The total liability of Travel MedEvac and its Assistance Provider, Medical Evacuation Provider, managers, employees, agents, affiliates, distributors, successors, and assigns relating to or arising out of the plan or the services provided hereunder shall not exceed the amount equal to the plan and policy fees paid to date during the current term of your plan. Medical evacuation transportation made pursuant to the plan is subject to rules and limitations of certain international treaties

governing international air travel, including but not limited to the Warsaw convention and/or the Montreal convention, which limit the liability of air carriers with respect to death or injury of passengers, for loss or destruction of baggage, or for delay.

The travel protection plan assistance services as defined constitute a summary of the agreement between Travel MedEvac and the Plan Holder. All legal actions arising under or relating to the assistance services provided or arranged by Travel MedEvac through the Assistance Provider and its Medical Evacuation Providers for you under your plan, shall be barred unless written notice thereof is received by us within six (6) months from the date of the services provided.

You further agree to waive the right to trial by jury in any action arising out of or relating to any assistance services provided or arranged by Travel MedEvac and its Assistance Provider or their Medical Evacuation Providers for you under your plan. Your plan cannot be transferred or assigned by you, and any attempted transfer or assignment shall be null and void.

Travel MedEvac, the Assistance Provider and its Medical Evacuation Providers, in its sole discretion, may monitor or electronically record communications between its employees or designated representatives and you in connection with your plan. By enrolling as a Plan Holder, you specifically authorize communications involving you and to which you are a party to be recorded and utilized by us for quality control or other purposes.

GENERAL DEFINTIONS

"Assistance Provider" means the company contracted with Travel MedEvac to provide assistance and claims services to our Plan Holders.

"Medical Evacuation Provider" means our Assistance Provider's global network of highly accredited air ambulance and medical evacuation assistance companies.

"Medical Personnel" means a licensed physician employed by or contracted with the Assistance Provider or Medical Evacuation Provider to serve in a medical and administrative capacity as the head of the medical personnel employed by or contracted with the Assistance Provider.

"Medical Assessment" means an assessment of a patient's medical condition secured by our Assistance Company working in conjunction with the Medical Evacuation Provider's medical director and in collaboration with the attending physician. The Assistance Company in collaboration with the Medical Evacuation Provider, will utilize the assessment to determine at its sole discretion whether a Plan Holder is fit to fly; the most appropriate means to provide medical evacuation; the medical personnel who will be accompanying the patient on the transport; and to confirm the medical facility closest to one's home can meet their medical needs. If the patient's medical facility of choice is unable to provide the high level of medical care required by the patient, arrangements will be made to transport the patient to the appropriate medical facility closest to their home, or closest to patient's preferred medical facility in the US when possible.

"Mexico Only" means a plan designed for those who only seek coverage when traveling in Mexico during the term of their plan per the eligibility requirements.

"Plan Holder" or "Plan Holders" means the individuals listed on the Travel MedEvac enrollment application, whose Travel MedEvac enrollment application has been accepted and approved by us and who have fully paid the applicable plan fees. The Plan Holder is alternatively referred to as "you," "your," or the "patient."

"Physician" means a doctor of Medicine (M.D.) or doctor of Osteopathy (D.O.), who is licensed in the jurisdiction where either the sending or receiving medical facility is located, and who is not the Plan Holder's spouse/domestic partner or the child, brother, sister, parent, or grandparent of the Plan Holder or the Plan Holder's spouse/domestic partner.

"Medical Evacuation Provider" means a licensed direct air carrier and/or ground ambulance company selected by the Assistance Provider to provide and arrange your medical evacuation transportation.

"Suitable Airport" means such location, construction, and facilities to safely accommodate the landing, ground services, maintenance requirements, and take-off of the fixed-wing aircraft assigned by Travel MedEvac.

"Travel MedEvac" means Travel MedEvac and its affiliates, successors, and assign Travel Med Evac, LLC is alternatively referred to herein as "we," "us," or "our"

"Travel MedEvac Plan Terms and Conditions" includes this agreement, your approved Travel MedEvac enrollment application, and the terms published on the most current Travel MedEvac plan documents, plan cost and term sheets on the date of your enrollment.

ELECTRONIC SIGNATURE

You represent and warrant that you have the legal right, power, and authority to agree to the terms of the plan terms and conditions on behalf of yourself, your dependent(s), and any other individual or entity on whose behalf you are acting. You further agree that your action of clicking the "I Agree" checkbox constitutes an electronic signature as defined by the Electronic Signatures in Global and National Commerce Act ("E-Sign") and the Uniform Electronic Transactions Act ("UETA"); that you have executed, entered into, accepted the terms of, and otherwise authenticated the plan terms and conditions; and that you acknowledge and agree that the plan terms and conditions are an electronic record for purposes of E-Sign, UETA, and the Uniform Computer Information Transactions Act ("UCITA") and, as such, are completely valid, have legal effect, are enforceable, and are binding on, and non-refutable by, you, your dependent(s), and any other individual or entity on whose behalf you are acting.

PLAN COSTS, PLAN FEES AND TERM OF PLAN

The plan fees and plan costs are as published on the most current Travel MedEvac plan documents and fees term sheet on the date of your enrollment. Your plan is not transferable should a Plan Holder on your plan become deceased. Plan fees and plan costs are non-refundable, except for refunds due to termination of your plan by Travel MedEvac or if a request is made within fifteen (15) days of enrollment confirmation and prior to leaving on your trip and prior to the Plan start date. If eligible, your plan payment (less any plan fees charged) will be fully refunded provided you have not incurred a covered expense or filed a claim. When payment is returned, all the Plan documents are void from the beginning.

CONTACT – GENERAL INFORMATION

Email: info@travelmedevac.com

Main Phone: 1-888-963-4933

Outside the USA or Canada Dial: 1-602-344-9225

Travel MedEvac Mailing Address (Not Used For Claims Reimbursement Submission)

Travel MedEvac

2550 E. Rose Garden Lane #72566

Phoenix, Arizona USA 85050

www.travelmedevac.com