THIS IS THE POLICY DOCUMENT FOR THE INF ADVANTAGE PLAN [Policy No. SRPO-75000-8030 – SRPO-75000-8031] - ADMINISTERED BY INF HEALTH CARE AND UNDERWRITTEN BY AXIS INSURANCE COMPANY, CHICAGO, IL

MEDICAL EXPENSE BENEFITS – ACCIDENT AND SICKNESS

PRE-EXISTING CONDITIONS COVERAGE OPTION (LIMITED TO ACUTE ONSET)

Pre-Existing Condition Coverage only Extends to Insured when Pre-Existing Coverage Option is chosen in the Enrollment Form.

This feature of the INF Health Care Accident and Sickness Insurance Program provides coverage for Pre-Existing Conditions, defined as an illness, disease, injury or other condition of the Insured Person before the Insured Person's coverage became effective under the Policy:

1. Was treated by a Physician or treatment had been recommended by a Physician.
2. Required taking prescribed drugs or medicines, or
3. first manifested itself, worsened, became acute or exhibited symptoms that would have caused an ordinarily prudent person to seek diagnosis.

Pre-Existing Conditions coverage is limited to Acute Onset coverage. If you experience an acute onset of a pre-existing condition, benefits are payable according to your policy benefits. Treatment for said condition must be obtained within 12 hours of the sudden and unexpected outbreak or reoccurrence.

****For Individuals who select Non-Pre-Existing Coverage Option:**

Pre-Existing Conditions, defined as an illness, disease, injury or other condition of the Insured Person that in the *365 day period* before the Insured Person's coverage became effective under the Policy.

MEDICAL EXPENSE BENEFITS (PRE-EXISTING AND NON-PRE-EXISTING OPTIONS)

We will pay Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident or Sickness. These benefits are subject to Deductible of $250, $500 or $1000 for $75,000 policy maximum (ages 70-89) or $250, $500 or $1000 for $150,000 policy maximum (ages 69 and under) per person for each Injury and each Sickness as show in the table below.

Policy Max	New Sickness Deductible	Pre-Existing Max	Pre-Existing Deductible
$150,000 (Age 0-69)	$250 | $500 | $1000	$150,000 (Age 0-69)	$250 | $500 | $1000
$75,000 (Age 70-89)	$250 | $500 | $1000	$75,000 (Age 70-89)	$250 | $500 | $1000
$150,000 (Age 0-69)	$250 | $500 | $1000		
$75,000 (Age 70-89)	$250 | $500 | $1000		

The Policy Maximum for all Accident and Sickness Benefits and Pre-existing conditions is $150,000 (Age 0-69) and $75,000 (Age 70-89). Benefits are also subject to the following:

Co-Insurance Limits:

In-Network: 80% of covered Network charges up to a policy maximum per Insured Person per Covered Injury or Sickness.

Out-of-Network: 80% of Usual and Customary Charges up to a policy maximum per Insured Person per Covered Injury or Sickness.

Network Provider: First Health Network

Click Here to Search for Providers Near You Medical Expense Benefits are only payable: (1) for Usual and Customary Charges incurred after the Deductible, if any, has been met; (2) for those Medically Necessary Covered Expenses that the Covered Person incurs; (3). for charges incurred for services rendered to the Covered Person while on a covered Trip; and (4) provided the first charge is incurred within 90 days of the Covered Accident or Sickness. Payment for Covered Expenses will not exceed the Policy Maximum shown above.

Covered Medical Expenses include:

- Hospital Room (semi private) and Board and Miscellaneous Hospital Expenses. Covered Expenses charged 1) daily semi private room rate when Hospital confined; and 2) general nursing care provided and charged by the Hospital. Miscellaneous Expenses include, while Hospital confined; or 2) for preadmission expenses for being Hospital confined but are not limited to, the cost of the operating room, X-ray examination , laboratory tests, in-hospital physiotherapy, anesthesia; drugs (excluding take home drugs) or medicines, therapeutic services; and supplies, registered nurse services and all necessary charges other than room and board, for services received during a Hospital Stay
- Hospital Intensive Care Unit Covered Expenses charged when an Insured Person becomes confined as an Inpatient to a Hospital in an Intensive Care Unit, the Company will pay an additional benefit equal to the Daily Intensive Care Unit Benefit Amount shown in the Rider Schedule of benefits. Only one Daily Intensive Care Unit Benefit is provided for any one day of Intensive Care Unit confinement, regardless of the number of Covered Injuries or Sickness for which the confinement is required.
- Surgeon Services (Inpatient) - Covered Expenses charge for performing in-patient surgical procedure. Two or more surgical procedures through the same incision will be considered as one procedure. . However, the Company will pay up to 50% of the benefit for a surgical procedure when more than one surgical procedure through different operating fields is performed during the same surgical session. Covered Expenses will be paid under this inpatient surgery benefit; or under the Out Patient surgery benefit, but not for both.
- Anesthetist Services (Inpatient) - Covered Expenses charged by a Physician in connection with inpatient surgery for anesthesia and its administration. . Covered Expenses will be paid under this inpatient surgery benefit; or under the Out Patient surgery benefit, but not for both
- Assistant Surgeon (inpatient) – Covered Expenses charged by a Physician in connection with inpatient surgery. . Covered Expenses will be paid under this inpatient surgery benefit; or under the Out Patient surgery benefit, but not for both
- Physician's (non Surgical Inpatient visit) – Covered Expenses charged by a Physician for other than pre or post operative care, second opinion or consultation. for 1) in Hospital visits and office visits. Benefits are limited to one Physician visit per day. Covered Expenses will be paid under the impatient benefit or outpatient benefit for Physicians Office visits but not both.
- Consulting Physician Services- Covered Expenses charges by a Physician for a second surgical opinion or consultation that has been that must be requested by the attending Physician.
- Physiotherapy Benefits (inpatient) Covered Expenses charges by a Physician for Physiotherapy that must be requested by the attending Physician
- Pre – Admission Tests- Covered Expenses charged for pre- admission tests limited to routine test such as complete blood count; urinalyses and chest X ray. If otherwise payable under this Policy, major diagnostic procedures such as Cat-Scans; NMR's and blood chemistries will be paid under the Hospital Miscellaneous benefit.
- Surgeon Services (Outpatient) – Covered Expenses charge for performing outpatient surgical procedure. Two or more surgical procedures through the same incision will be considered as one procedure. . However, the Company will pay up to 50% of the benefit for a surgical procedure when more than one surgical procedure through different operating fields is performed during the same surgical session. Covered Expenses will be paid under this inpatient surgery benefit; or under the surgeon services benefit (Outpatient), but not for both.

- Day Surgery Miscellaneous Expenses(Outpatient) – Covered Expense related to a major surgery performed at Hospital or licensed Outpatient surgery center including the actual cost of the operating room, laboratory tests and x ray examination anesthesia, drugs, medicines and medical supplies related to the surgery. Does not include non scheduled surgery and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic.
- Anesthetist Services (Outpatient) - Covered Expenses charged by a Physician in connection with Anesthetist Services for Outpatient surgery for anesthesia and its administration. . Covered Expenses will be paid under this Outpatient benefit; or under the Inpatient surgery benefit, but not for both
- Assistant Surgeon (Outpatient) – Covered Expenses charged by a Physician in connection with Outpatient surgery. Covered Expenses will be paid under this Outpatient surgery benefit; or under the Inpatient surgery benefit, but not for both.
- Diagnostic X Rays and Lab tests except dental x-rays (Outpatient) – Covered Expenses incurred for the treatment of a Covered Injury or Sickness as prescribed by a Physician. CAT Scan, PET Scan or MRI tests (Outpatient) -Covered Expenses incurred for the treatment of a Covered Injury or Sickness as prescribed by a Physician
- Hospital Emergency Room services – Covered Expenses incurred for the Outpatient emergency room treatment performed in a Hospital. When emergency room treatment is immediately followed by admission to a Hospital, such treatment will be a Hospital Room and Board and Miscellaneous Hospital Covered Medical Service.
- Prescriptions (outpatient) – Covered Expenses incurred for the treatment of a Covered Accident or Sickness prescribed by a Physician.
- Ambulance Services Covered Expenses incurred for ground or air ambulance service to transport the Insured Person from the place where the Covered Accident or occurs. The Company will pay Covered Expenses incurred for ground or air ambulance transportation from the nearest medical facility to another appropriate medical facility, if a Physician specifies in writing that specialized care not available in the first facility to which the Insured Person was transported is necessary to treat His Covered Injury or Sickness.
- Initial Orthopedic Prosthesis or Brace - Covered Expenses incurred for the initial purchase, fitting, and needed adjustment of such appliances or devices, including the components of prosthetic appliances. Orthopedic prosthesis or brace include durable medical equipment which is equipment that 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. The Orthopedic Prosthesis or Brace must be prescribed by a Physician and a written prescription must accompany the claim when submitted. Replacement prosthesis and braces are not covered and no benefits will be paid for rental charges in excess of the purchase price.
- Dental Injury Treatment - Covered Expenses incurred for dental treatment (does not include dental services for the immediate relief of pain), including X-rays, for injury to a tooth: 1) with no fillings or cavities or only fillings or cavities that do not undermine the tooth cusps; and 2.for which pulpal tissues are healthy and intact; and 3. for which periodontal tissue shows little or no signs of active or chronic inflammation. For insurance review purposes, each tooth unit is evaluated under these criteria rather than a blanket rating of the whole mouth. Covered Expenses include examinations, x-rays, restorative treatment, endodontic, oral surgery, initial braces required for treatment of a Covered Injury and treatment of gingivitis resulting from trauma. If there is more than one way to treat a dental problem, The Company will pay based on the least expensive procedure if that procedure meets commonly accepted standards of the American Dental Association. Routine dental care and treatment to the gums are not covered.
- Chemotherapy and/or Radiation Services – Covered Expenses incurred for chemotherapy or radiation prescribed by a Physician for the treatment of a Sickness Benefits. Chemotherapy and Radiation means Cobalt Therapy, EX- ray therapy or chemotherapy administered to an Insured Person as treatment of cancer. This includes Injections 1) when administered in the Physician's office; and 2) charged on the Physician statement. It does not include laboratory and diagnostic tests.
- Physical and Occupational Therapy Covered Expenses incurred for Outpatient physical and occupational therapy
- Private Duty Nursing Benefit Covered Expenses incurred for services rendered by a 1) private duty nurse care only; 2) while Hospital Confined; 3) ordered by a licensed Physician; and 4) medically necessary. General nursing care provided by the Hospital is not covered under this benefit.
- Maternity Benefit Covered Expenses incurred for the treatment of a pregnancy when conception occurs after the trip begins under this Policy. This does not include any benefits for the unborn child.
- Covered Pregnancy Complications Include: Acute nephritis or nephrosis; or Pre-eclampsia; Eclampsia puerperal infection; or RH Factor problems; or Severe loss of blood requiring transfusion; or Cardia decomposition or missed abortion; or
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Similar condition as severe as these above; Non elective cesarean section; and Termination of an ectopic pregnancy; and Spontaneous termination when live birth is not possible (This does not include voluntary or elective abortion)

- Delivery by cesarean section is considered a eco of Pregnancy if the cesarean section is non elective. A cesarean section will be considered non elective if the fetus or the mother is determined to be in distress and is in immediate danger of death, Sickness or Covered Injury if the cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non elective if vaginal delivery is medically inappropriate, or vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or injury to child or mother.
    - Not included: (a) false labor, occasional spotting or Physician prescribed rest during the period of pregnancy; (b) morning sickness; (c) hyperemesis gravidarum and (d) similar conditions not medically distinct from a difficult pregnancy.

PERIODS OF COVERAGE & PREMIUM RATES

Premium Rates in all tables (www.infplans.com/inf-easy-select-premiums.php) are per month (30 days coverage) and any single days premium is prorated based on 30 day monthly premium.

Enrollment is subject to the following rules:

- You must enroll and pay premium for at least 30 days of coverage
- You may enroll for up to 300 consecutive days and pay the required premium at the time of enrollment
- You must pay the full premium for the requested months at the time of enrollment
- A $15 application fee will be charged for each enrollment and is non-refundable even if insurance is canceled.
- If you are on a Trip and wish to extend your coverage you may enroll for an additional period subject to a minimum period of one day and an overall maximum period of 12 months.

PROGRAM ELIGIBILITY

You are eligible to elect this insurance is you are an active member of the INF and are visiting the USA or Canada. Members are auto-enrolled in membership by paying $15 application fee. Membership expires at the termination date of each policy. Membership fees are required for new applications & renewals.

All Visitors & Travelers to the United States (included Non-US Citizens & US Citizen Expatriates visiting the United States) are eligible to enroll in this policy. You may elect coverage for your Eligible Dependents traveling with you.

Eligible Dependents are any of the following persons: the insured member's legal spouse, and their unmarried dependent children under 19 years of age (19 years and older if a child is incapable of self-sustaining employment due to physical or mental handicap).

If adoption, birth or marriage occurs while the insured member is covered under this insurance, the insured member will have 31 days within which to enroll a newly eligible dependent and pay the required premium for coverage to continue for the remainder of the period of coverage.

INSURANCE ENROLLMENT

To enroll in the INF HEALTH CARE Accident & Sickness Insurance Program, you may enroll online or submit paper application from your agent. Click here to complete application online. To enroll in the health plans offered, follow the steps listed below:

1. Complete the Insurance Enrollment Form

2. Submit the forms either electronically or as shown below.

VIA FAX:

Fax the membership and enrollment forms (fax versions of the forms are available under download link) with charge authorization to 408-520-4967

VIA MAIL:

Mail a check for the exact amount with completed enrollment forms: the membership form & insurance form. Prepare two checks:

1. Application fee of $15 made payable to INF Health Care, LLC and

2. Premium amount made payable to 'INF Health Care, LLC' and mail the package to:

INF Health Care
7065 Westpointe Blvd, Suite 209
Orlando, FL 32835-8758

Processing of an insurance enrollment may take up to 2 working days. Fulfillment is completed electronically. Physical delivery of an ID card is subject to an additional $5 processing fee. Requests may be submitted to operations@infplans.com

COVERAGE

The INF Group Policy Effective Date is June 1, 2018

Coverage for a member and any eligible dependents who enroll in this program will begin at 12:01 a.m. on the latest of the following dates, whichever is applicable:

Insured's Effective Date: Insurance under this Policy shall become effective on the latest of the following dates:

1. The Effective Date of the Policy;
2. The date the Insured leaves their Country of Residence;
3. The date the Insured's enrollment form is received by the INF Health Care;
4. The date the Insured's premium is received by the INF Health Care; or
5. The date the Insured requested on the Application.

Dependent's Effective Date:

Insurance under this Policy shall become effective on the latest of the following dates:

1. The date the insured member's coverage becomes effective;
2. The date the Dependent leaves their Home Country or Country of Residence; or
3. The date the person becomes a dependent (as defined).

Insured's Termination Date:

The coverage provided with respect to the insured member shall terminate on the latest of the following dates:

1. The last day of the period for which the premium is paid;
2. The date the insured member returns to his or her Home Country or Country of Residence;
3. The expiration of the maximum coverage period; or
4. The date the Policy terminates.

Dependent's Termination Date:
The coverage provided with respect to the insured member's covered Dependents shall terminate on the latest of the following dates:

1. The date the insured member's coverage ends;
2. The last day of the period for which the premium is paid;
3. The date an insured Dependent return to his or her Home Country or Country of Residence;
4. The expiration of the maximum coverage period; or
5. The date the Policy terminates.

Termination of Coverage will not affect a claim for a covered loss that occurred while the insured member's coverage was in force under this policy. This coverage will not duplicate benefits available from other valid and collectible insurance. If a covered person's Injury or Sickness is due to an act or omission of another, benefits payable by this program are subject to recovery from amounts paid to, or on behalf of, the covered person.

NOTE: If coverage is purchased after the Insured Person's arrival in the United States, coverage under this Rider is limited to Accident only during an Insured Person's 14 days of coverage commencing on the Insured Person's Effective Date. Full coverage will take place after the 14th day.

DEFINITIONS

- **Benefit Period** as used in this Rider means the maximum period that benefits are payable under this Rider.
- **Complication(s) of Pregnancy** mean(s) conditions which require Hospital Stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are
- Acute nephritis or nephrosis; or
- Pre eclampsia; or
- Eclampsia puerperal infection; or
- RH Factor problems; or
- Severe loss of blood requiring transfusion; or
- Cardia decomposition or missed abortion; or
- Similar condition as severe as these above;
- Non elective cesarean section; and
- Termination of an ectopic pregnancy; and
- Spontaneous termination when live birth is not possible (This does not include voluntary or elective abortion)
- Delivery by cesarean section is considered a eco of Pregnancy if the cesarean section is non elective. A cesarean section will be considered non elective if the fetus or the mother is determined to be in distress and is in immediate danger of death, Sickness or Covered Injury if the cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non elective if vaginal delivery is medically inappropriate, or vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or injury to child or mother.
- Not included: (a) false labor, occasional spotting or Physician prescribed rest during the period of pregnancy; (b) morning sickness; (c) hyperemesis gravidarum and (d) similar conditions not medically distinct from a difficult pregnancy.
- **Covered Expenses** as used in this Rider means expenses actually incurred by or on behalf of an Insured Person for treatment, services and supplies covered by this Policy. Coverage under the Policyholders' Policy must remain continually in force from the date of the Covered Accident or Sickness until the date of treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date treatment, service or supply that gave rise to the expense or the charge, was rendered or obtained.

- **Covered Injury** as used in this Rider means bodily Injury; 1) directly and independently caused by specific accident which is unrelated to any pathological, functional, or structural disorder to Injury; 2) treated by a Physician within 30 days after the Covered Accident; and 3) which caused loss during the term of this Rider.
- **Covered Trip** as used in this Rider, means travel by air, land or sea from the Insured Person's Home Country.
- **Deductible** as used in this Rider means the amount that must be paid for Covered Medical Services by the Insured Person before benefits will become payable under this Rider. A separate deductible shall apply to each Covered Loss.
- **Home Country** as used in this Rider means a country from which the Insured Person holds a passport or where the Insured Person has primary residency. If the Insured Person holds passports from more than one Country, his or her Home Country will be the country that he has declared to Us in writing as his Home Country
- **Hospital** - as used in this Rider, means a facility that:
- is operated according to law for the care and treatment of injured people;
- has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis;
- has 24 hour nursing service; and
- is supervised by one or more Physicians.
- A Hospital does not include:
- a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care;
- a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes; or
- any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.
- **Hospital Confined** as used in this Rider means a stay of 48 or more consecutive hours as a registered resident bed-patient in a Hospital.
- **Intensive Care Unit (ICU)** as used in this Rider means specifically designated facility of the Hospital that is designed to provide intensive care services on an interdisciplinary basis to critically ill inpatients. provides the highest level of medical care and that is restricted to those patients who are critically ill or injured and need constant medical care. Such care must be ordered by a Physician. The facility must provide: room and board, registered nursing care, and special equipment and supplies on a standby basis. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement.
- **Medically Necessary** - as used in this Rider refers to a Covered Medical Service that:
    - is essential for diagnosis, treatment or care of the Covered Injury or Sickness for which it is prescribed or performed;
- meets generally accepted standards of medical practice; and
- is ordered by a Physician and performed under his care, supervision or order
- **Physiotherapy** as used in this Rider means any form of the following: physical or mechanical therapy, diathermy, ultrasonic therapy; heat treatment in any form; manipulation or massage administered by a Physician. It does not include chiropractic care.
- **Prescription Drugs** as used in this Rider means 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4 Injectable insulin.
- **Physician** as used in this Rider means a licensed health care provider practicing within the scope of his license and rendering care and treatment to the Insured Person that is appropriate for the condition and locality, and who is not:
    - the Insured Person;
    - an Immediate Family Member of either the Insured Person or the Insured Person's Spouse;
    - a person living in the Insured Person's household; or
    - a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

- **Sickness** as used in this Rider means disease or illness, including related conditions and recurrent symptoms, which begin after the effective date of an Insured Person's coverage and while coverage is in force under this Rider.
- **Usual and Customary Charge(s)** - as used in this Rider means a charge that:
- is made for a Covered Medical Service;
- does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred (for a Hospital room and board charge, other than for a Medically Necessary stay in an intensive care unit or a cardiac care unit, does not exceed the Hospital's most common charge for semi-private room and board); and
- does not include charges that would not have been made if no insurance existed.

Exclusions and Limitations:

The Company will not pay Covered Medical Services for any loss, treatment or services resulting from the following.

- Expenses incurred during travel for the purposes of seeking medical care or treatment, or while on a waiting list for specific treatment or while traveling against the advice of a Physician.
- Expenses incurred within the Insured Person's Home country or country of regular domicile,
- Pre-existing Conditions, except for the Acute Onset as specifically provided in the Rider Schedule.
- Routine physical or other examinations where there is not objective indications of impairment for normal health or well baby care.
- Dental treatment, except as the result of Covered Injury to sound, natural teeth as stated in the *Rider Schedule*.
- Cosmetic or plastic surgery or treatment for congenital abnormalities, except reconstructive surgery as a result of a as the result of a Covered Injury or Sickness. Correction of a deviated nasal septum is considered cosmetic surgery unless it results from a Covered Injury or Sickness
- eye refractions or eye examinations for the purpose of prescribing corrective lenses or for the fitting thereof; eyeglasses, contact lenses
- Hearing examination or hearing aids or other treatment for Hearing Defects and problems. Hearing Defects means any physical defect of the ear which does or can impair normal hearing.
- Treatment by any Immediate Family member or member of the Insured Person's household. "Immediate family member "means an Insured Person's spouse, child, brother, sister, grandparents or in laws.
- Services, supplies, or treatment including any period of Hospital Confinement which is not recommended, approved, and certified as Medically Necessary and reasonable by a Physician, or expenses which are non-medical in nature;
- In connection with alcoholism and drug addiction, or use of any drug or narcotic agent unless prescribed by a Physician;
- the commission of a felony offense;
- Charges for Covered
- for which the Insured Person would not be responsible for in the absence of this Rider**;**
- Any expense paid or payable by any Other Health Care Plan;
- Any treatment provided under any mandatory government program or facility set up for treatment without cost to any individual
- Treatment , services supplies or facilities in a Hospital owned or operated by the Veteran's Administration, or b) a national government or any of its agencies(this exclusion does not apply to treatment when a charge is made which the Insured Person is required by law to pay)
- Elective treatment, exams or surgery; elective termination of pregnancy.
- Expenses for services, treatment or surgery deemed to be experimental and which are not recognized and generally accepted medical practices in the United States.
- Expenses payable by any automobile insurance policy without regard to fault.
- Organ or tissue transplants and related services.
- Expenses incurred for services related to the diagnostic treatment of infertility or other problems related to the inability to conceive a child, including but not limited to, fertility testing and in-vitro fertilization.
- Birth control including surgical procedures and devices.
- Expenses incurred in connection with weak, strained or flat feet, corns, calluses or toenails.
- Birth defects and congenital anomalies, or complications which arise from such conditions.
- Sexually transmitted diseases or immune deficiency disorders and related conditions. This exclusion does not apply to the care or treatment of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection, or any illness or disease arising from these medical conditions.
- specific named hazards: piloting any aircraft;

- Expenses incurred for any treatment if the Insured Person is travelling against the advice of a Physician.
- Expenses incurred after the date insurance terminates for an Insured Person under this Policy
- Any mental or nervous disorders or rest cures;
- Duplicates services actually provided by both a certified nurse- midwife and Physician**.**
- Expenses payable under any prior Policy which was in force for the person making the claim.
- Expenses incurred in a Hospital emergency room visit which is not of an emergency nature.
- Expenses incurred for chiropractic care-outpatient treatment in connection with the detection or correction by manual or mechanical means of structural imbalance distortion or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertical column.
- Injury sustained while participating in club, intramural, intercollegiate, interscholastic, professional or semi-professional sports

In addition, benefits will not be paid for services or treatment rendered by any person who is:

1. employed or retained by the Policyholder;
2. living in the Insured Person's household;
3. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse;
4. the Insured Person.

If we determine the benefits paid under this Rider are eligible benefits under any Other Health Care Plan, We may seek to recover any expenses covered by the Other Health Care Plan to the extent that the Insured person is eligible for reimbursement.

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit US companies from proving insurance, including but not limited to, the payment of claims. All other terms and conditions of the Policy and this Rider remain unchanged.

Europ TRAVEL ASSISTANCE SERVICES

Europ Assistance can help travelers with medical emergencies by:

- Emergency Medical Evacuation & treatment en-route if necessary
- Repatriation of remains in the event of Insured Persons death
- Medical emergencies and many other services (see web)

The Europ Assistance communications network is available 24 hours a day, seven days a week to provide assistance to the Insured Person.
Inside the United States/Canada call (877) 243-4134
Outside United States/Canada call collect 240-330-1528
or email OPS@europassistance-usa.com

TELADOC PROGRAM

The Teladoc program is available 24 hours a day, seven days a week and provides you with access to a physician in the United States for any medical consultation and short-term prescription refills. This program is not insurance. Find more information on how to enroll in a Teladoc account by clicking here.

Teladoc does not replace the primary care physician. Teladoc does not guarantee that a prescription will be written. Teladoc operates subject to state regulation and may not be available in certain states. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services.

Services are provided by third-party agreements and are not insurance. These services include travel assistance services through Europ Assistance, USA and physician consultation services through Teladoc.

CLAIMS

Claims process begins by submitting a duly completed online claim form found on the website under Members Area. The claim form has two sections. First section should be completed online by the Insured Person; and the second section should be completed by the provider (doctor office or hospital, etc.)
Providers or Insured Persons can submit the fully completed claim form to WebTPA Claims Office below.

MAIL CLAIM FORMS TO:
WebTPA
PO Box 99906
Grapevine, TX 76099-9706
fax (469) 417-1989

If We determine the benefits paid under this Policy are eligible benefits under any other benefit plan, We may seek to recover any expenses covered by another plan to the extent that the Insured Person is eligible for reimbursement.

Payment of claims under any policy issued shall only be made in full compliance with all economic or trade and sanction laws or regulations, including but not limited to, laws and regulations administered and enforced by the US Treasury Department's Office of Foreign Assets Control.

CLAIM QUESTIONS

All claims related questions should be addressed to WebTPA Claims Office after claims have been submitted; and more than six weeks elapsed. Contact claims office between 8:00 AM and 8:00 PM (EST) Monday through Friday at: **(928) 494-0112**

OTHER BENEFITS - MEDICAL EVACUATION AND REPATRIATION BENEFITS

EMERGENCY MEDICAL EVACUATION AND REPATRIATION: These Benefits will not be payable unless We (or Our authorized travel assistance provider) authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our a travel assistance provider. Contact Europ Assistance for these services at (877) 243-4134 or call collect from outside the United States at (240) 330-1528 (24 hours a day, 7 days a week). Email: OPS@europassistance-usa.com

EMERGENCY MEDICAL EVACUATION BENEFIT: We will pay Emergency Medical Evacuation Benefits as shown for Covered Expenses incurred for the Emergency Evacuation of a Insured Person. Benefits are payable up to the Benefit Maximum shown, if the Insured Person suffers a Covered Injury or Emergency Sickness during the course of the Covered Trip that requires Emergency Evacuation.

REPATRIATION OF REMAINS BENEFIT: We will pay Repatriation Benefits up to the Benefit Maximum shown for preparation and return of a Insured Persons body to his or her place of primary residence if he or she dies as a result of a Covered Injury or Emergency Sickness while traveling on a Covered Trip.

ACCIDENTAL DEATH AND DISMEMBERMENT: If Injury to the Insured Person results, within 365 days of the date of a Covered Accident, in any one of the losses shown below, We will pay the Benefit Amount shown below for that loss. The Aggregate Sum is $500,000 as shown. If multiple losses occur, only one Benefit Amount, the largest, will be paid for all losses due to the same Covered Accident.

Covered Loss	Benefit Amount
Loss of Life	100% of the Aggregate Sum
Loss of Two or More Hands or Feet	100% of the Aggregate Sum
Loss of Sight of Both Eyes	100% of the Aggregate Sum
Loss of One Hand and Foot	100% of the Aggregate Sum
Loss of One Hand or Foot and Sight in One Eye	100% of the Aggregate Sum
Loss of One Hand or Foot	50% of the Aggregate Sum
Loss of Sight in One Eye	50% of the Aggregate Sum
Exposure and Disappearance	Included

Cancellation Policy

Refund of premium, less a $25 processing fee, will be considered only if the Cancellation Form is received by the INF Health Care prior to the effective date of coverage. After that date, the premium is considered fully earned and non-refundable. All cancellation requests should be submitted by completing the Cancellation Form found at the following link: INF Cancellation Form. The form can be faxed to 408-520-4967. Policy changes cannot be made under any circumstances once the policy becomes effective.

This is a brief description of the coverage provided under the policy, and is subject to the terms, conditions, limitations and exclusions of the policy. Please see the policy for details. This insurance includes limited benefits. Limited benefits plans are insurance products with reduced benefits and are not intended to be an alternative to or integrated with comprehensive coverage. Further, this insurance does not coordinate with any other insurance plan. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act

IMPORTANT NOTICE

Insurance policies providing certain health insurance coverage issued or renewed on or after September 23, 2010 are required to comply with all applicable requirements of the Patient Protection and Affordable Care Act ("PPACA"). However, there are a number of insurance coverages that are specifically exempt from the requirements of PPACA (See §2791 of the Public Health Services Act). AXIS Insurance Company maintains this insurance is short-term, limited duration insurance and is not subject to PPACA.

AXIS Insurance Company continues to monitor federal and state laws and regulations to determine any impact on its products. In the event these laws and regulations change, your plan and rates will be modified accordingly.

Please understand that this is not intended as legal advice. For legal advice on PPACA, please consult with your own legal counsel or tax advisor directly.