THIS IS THE POLICY DOCUMENT FOR THE INF ELITE NETWORK PLAN [POLICY NO. GLMN10783434P]. THIS POLICY IS ADMINISTERED BY INF HEALTH CARE AND UNDERWRITTEN BY CHUBB AMERICAN INSURANCE COMPANY, PHILADELPHIA, PA.

MEDICAL EXPENSE BENEFITS – ACCIDENT AND SICKNESS

PRE-EXISTING CONDITIONS COVERAGE

This feature of the INF HEALTH CARE'S Accident and Sickness Insurance Program provides coverage for Pre-Existing Conditions, defined as an illness, disease, or other condition of the Covered Person that before the Covered Person's coverage became effective under the Policy: (1) first manifested itself, worsened, became acute, or exhibited symptoms that would have caused a person to seek diagnosis, care, or treatment; or (2) required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or (3) was treated by a Doctor or treatment had been recommended by a Doctor.

Pre-Existing Conditions coverage is subject to a Maximum Benefit of $25,000 and Deductible of $1,500 (Age 69 & under) or a Maximum Benefit of $20,000 and Deductible of $1,500 (Ages 70-99). Pre-existing conditions covers pre-existing conditions on par with accidents and new sicknesses subject to special deductible and specific pre-existing policy maximum as specified above.

MEDICAL EXPENSE BENEFITS

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 a Deductible of $500 per person for each Injury and each Sickness. The Policy Maximum for all Accident and Sickness Benefits is $150,000 (Age 69 & under) and $75,000 (Ages 70-99). Benefits are also subject to the following:

Co-Insurance Limits:
In-Network: 80% of covered Network charges up to the overall maximum benefit.
Out-of-Network: 60% of covered Network charges up to the overall maximum benefit.
Deductible per individual sickness or injury: $500.
Policy Maximum Benefits per individual sickness or injury: $150,000 - Age 69 and under; $75,000 - Age 70-99.P
Pre-Existing deductible per individual sickness or injury: $1,500.
Pre-Existing Maximum Benefits per individual sickness or injury: $25,000 - Age 69 and under; $20,000 - Age 70-99.

Co-Insurance Limits In-Network: 80% of covered Network charges to the overall maximum benefit.
Out-of-Network: 60% of covered Up to the overall maximum benefit.

Network Provider: FirstHealth Network

Network means the FirstHealth Network. When a covered Injury or Sickness requires treatment by a Doctor, this Policy will provide benefits while coverage is in force for the Usual and Customary charges incurred which exceed the deductible per person for each Injury or Sickness. Payment for any covered service will be no more than the Benefit Limit shown for it. In no event will the total combined benefits for a single Injury or Sickness (either in a single Policy year or through continuing year's coverage) exceed the Policy Maximum Benefit. 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 semi-private room and board (or room and board in an intensive care unit.
- Hospital ancillary services (including, but not limited to, use of the operating room or emergency room).
- Doctor Non-Surgical Treatment/Examination Expenses (excluding medicines) including the Doctor's initial visit, each Medically Necessary follow-up visit and consultation visits when referred by the attending Doctor.
- Doctor's Surgical Expenses. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session but through different incisions, We will pay pursuant to the Co-Insurance limits as shown above for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.
- Assistant Surgeon Expenses when Medically Necessary.
- Services of a Doctor or a registered nurse (R.N.).
- Ambulance service to or from a Hospital.
- Outpatient diagnostic X-rays, laboratory procedures and tests.
- Laboratory tests.
- Radiological procedures.
- Anesthetics and their administration.
- Blood, blood products, artificial blood products, and the transfusion thereof.
- Inpatient Physiotherapy.
- Medicines or drugs administered by a Doctor or that can be obtained only with a Doctor's written prescription.
- Dental charges for Injury to sound, natural teeth.
- Emergency medical treatment of pregnancy.
- Therapeutic termination of pregnancy.
- Artificial limbs or eyes (not including replacement of these items).
- Casts, splints, trusses, crutches, and braces (not including replacement of these items or dental braces).
- Oxygen or rental equipment for administration of oxygen.
- Rental of a wheelchair or hospital-type bed.
- Rental of mechanical equipment for treatment of respiratory paralysis.
- Pre-admission testing.
- Radiation Therapy.
- Chemotherapy.
- Outpatient injections when administered in a Doctor's office
- Consultation visits.

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 minimum 90 days required.
- You may enroll for up to 12 consecutive months 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; when processing is complete, if you enroll for a coverage term of 1 month or more. 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

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 returns 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.

CONTINUOUS COVERAGE
Coverage for a Covered Person will be considered continuous during consecutive periods of coverage for up to 12 months if the required premium is received by INF Health Care prior to any subsequent period of coverage purchased for a Covered Person. The continuation of coverage will not establish a new benefit period, nor affect maximum benefits or benefit periods for a loss incurred during any preceding coverage period.

DEFINITIONS
"Country of Permanent Assignment" means a country, other than your Home Country, in which the Policyholder requires you to work for a period of time that exceeds 364 continuous days.

"Country of Permanent Residence" *means a country or location in which you maintain a primary permanent residence.*

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

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

*"**Covered Person**" means any eligible person for whom the required premium is paid.*

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

"Dependent" *means an Insured's lawful spouse or an Insured's unmarried child, from the moment of birth to age 19, 25 if a full-time student, who is chiefly dependent on the Insured for support. A child, for eligibility purposes, includes an Insured's natural child; adopted child, beginning with any waiting period pending finalization of the child's adoption; or a stepchild who resides with the Insured or depends on the Insured for financial support. A Dependent may also include any person related to the Insured by blood or marriage and for whom the Insured is allowed a deduction under the Internal Revenue Code.*

Insurance will continue for any Dependent child who reaches the age limit and continues to meet the following conditions: 1) the child is handicapped, 2) is not capable of self-support and 3) depends mainly on the Insured for support and maintenance. The Insured must send Us satisfactory proof that the child meets these conditions, when requested. We will not ask for proof more than once a year.

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

"Home Country" *means a country from which you hold a passport. If you hold passports from more than one Country, your Home Country will be the country that you have declared to Us in writing as your Home Country. Home Country also includes your Country of Permanent Assignment or Country of Permanent Residence.*

"Hospital" *means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment, and providing of inpatient services for sick or injured persons; 2) provides 24-hour nursing service by Registered Nurses on duty or call; 3)*

DEFINITIONS (Continued)

has a staff of one or more licensed Doctors available at all times; 4) provides organized facilities for diagnosis, treatment, and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a prearranged basis; 5) is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing, or section of a Hospital used as such; and 6) is not a place for drug addicts, alcoholics, or the aged.

*"**Injury"** means accidental bodily harm sustained by a Covered Person that results, directly and independently from all other causes, from a Covered Accident. All injuries sustained by one person in any one Covered Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.*

***"Insured"** means a person in a Class of Eligible Persons for whom the required premium is paid making insurance in effect for that person.*

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

***"Medically Necessary"** means a treatment, service, or supply that is: 1) required to treat an Injury or Sickness; 2) prescribed or ordered by a Doctor or furnished by a Hospital; 3) performed in the least costly setting required by the Covered Person's condition; and 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. Purchasing or renting 1) air conditioners; 2) air purifiers; 3) motorized transportation equipment; 4) escalators or elevators in private homes; 5) eyeglass frames or lenses; 6) hearing aids; 7) swimming pools or supplies for them; and 8) general exercise equipment are not Medically Necessary. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may consider the cost of the alternative to be the Covered Expense.*

***"Preexisting Condition"** means an illness, disease, or other condition of the Covered Person that before the Covered Person's coverage became effective under the Policy:*

1. first manifested itself, worsened, became acute, or exhibited symptoms that would have caused a person to seek diagnosis, care, or treatment; or

2. required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or

3. was treated by a Doctor or treatment had been recommended by a Doctor.

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

*"**Trip**" means travel by air, land, or sea from your Home Country. It includes the period of time from the start of the trip until its end provided you are engaged in a Covered Activity or Personal Deviation if covered under the Policy.*

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

*"**We, Our, Us"** means the insurance company underwriting this insurance or its authorized agent.*

Exclusions and Limitations:

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

- intentionally self-inflicted injury; suicide or attempted suicide.
- war or any act of war, whether declared or not.
- a Covered Accident that occurs while a Covered Person is on active duty service in the military, naval or air force of any country or international organization. Upon receipt of proof of service, we will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
- piloting or serving as a crew member in any aircraft (unless otherwise provided in the Policy).
- riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline
- commission of, or attempt to commit, a felony.
- sickness, disease, bodily or mental infirmity, bacterial or viral infection, or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food (Applicable to accident benefits only).
- the Covered Person being legally intoxicated as determined according to the laws of the jurisdiction in which the Injury occurred.
- commission of or active participation in a riot or insurrection.

In addition, We will not pay Medical Expense Benefits for any loss, treatment, or services resulting from:

- routine physicals and care of any kind.
- routine dental care and treatment.
- routine nursery care.
- cosmetic surgery, except for re constructive surgery needed as the result of an Injury.
- eye refractions or eye examinations for the purpose of prescribing corrective lenses or for the fitting thereof; eyeglasses, contact lenses, and hearing aids.
- services, supplies, or treatment including any period of Hospital confinement which is not recommended, approved, and certified as Medically Necessary and reasonable by a Doctor, or expenses which are non-medical in nature.
- treatment or service provided by a private duty nurse.
- treatment by any Immediate Family Member or member of the Insured's household. "Immediate Family Member" means a Covered Person's spouse, child, brother, sister, parent, grandparent, or in-laws.
- expenses incurred during travel for purposes of seeking medical care or treatment, or for any other travel that is not in the course of the Policyholder's activity (unless Personal Deviations are specifically covered).
- medical expenses for which the Covered Person would not be responsible to pay for in the absence of the Policy. Expenses incurred for services provided by any government Hospital or agency, or government sponsored-plan for which, and to the extent that, the Covered Person is eligible for reimbursement.
- any treatment provided under any mandatory government program or facility set up for treatment without cost to any individual.
- services or expenses incurred in the Covered Person's Home Country.
- 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.
- Preexisting Conditions, unless otherwise provided in the Policy.
- Any expense paid or payable by any other valid and collectible group insurance plan.
- Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation, whether United States federal or foreign law.
- Injury sustained while participating in club, intramural, intercollegiate, interscholastic, professional or semi-professional sports.

Exclusions and Limitations (Continued):

- 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.
- expenses incurred in connection with weak, strained or flat feet, corns, calluses or toenails.
- expenses incurred for birth control including surgical procedures and devices.
- 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.
- Pregnancy (unless treatment is required as a result of a Medical Emergency), childbirth, miscarriage, abortion or any complications of any of these conditions.

CLAIM PROCEDURE

It is required to file a claim with the Insurance company any time the insurance is used. Claims may be submitted to the Claims Administrator (Administrative Concepts Inc.) by the provider of service directly or by you, using the claim forms found in the Active Policies area of the MyINF Member Portal. All claims must be submitted using the applicable claim form, which can be found online or requested from the Claims Administrator.

Completed claim forms must be furnished to Administrative Concepts, Inc. within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to furnish proof.

Claims Office

Administrative Concepts, Inc. (ACI)
994 Old Eagle School Rd., Suite 1005
Wayne, PA 19087-1706
Toll Free: 888-293-9229 (from inside the U.S.)
Phone: 610-293-9229 (from outside the U.S.)
Fax: 610-293-9299
Web: http://www.visit-aci.com

Should you to check upon the status of your filed claim, or claims related questions you may call the claims office at the above number during business hours 7 AM to 7 PM (CST). Should you have questions regarding your brochure or insurance program, please contact INF Health Care. They can be reached by phone at 408-634-0065, from 9:00 AM to 6:00 PM (EST) during week days, Monday through Friday.

AXA Travel ASSISTANCE SERVICES (AVAILABLE FOR INSURED MEMBERS ONLY)

AXA Travel Assistance Services at 1-855-327-1414 will provide 24-hour access to the following services:

- Medical Assistance including referral to a doctor or medical specialist, medical monitoring when you are hospitalized, emergency medical evacuation to an adequate facility, medically necessary repatriation, and return of mortal remains.
- Personal Assistance including pre-trip medical referral information and while you are on a trip: emergency medication, embassy and consular information, lost document assistance, emergency referral to a lawyer, translator or interpreter access, medical benefits verification, and medical claims assistance.
- Travel Assistance including emergency travel arrangements, arrangements for the return of your traveling companion or dependents, and vehicle return.
- Access to a secure, web-based system for tracking global threats and health or location based risk intelligence.

You will receive information Travel Assistance on your Certificate of Insurance that will provide you with emergency call numbers. Information on how to access CHUBB's Travel Assistance Web Portal can be found in the brochure for this plan.

This information provides you with a brief outline of the services available to you. These services are subject to the terms and conditions of the Policy under which you are insured. Travel assistance services are not available if your coverage under the Policy providing insurance benefits is not in effect.

MeMD PROGRAM

The MeMD 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.

MeMD does not replace the primary care physician. MeMD does not guarantee that a prescription will be written. MeMD operates subject to state regulation and may not be available in certain states. MeMD 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.

Other Policies Features

Accidental Death and Dismemberment	$25,000 Maximum
Pre-certification	Not Required
Type of Coverage	Excess
Benefit Period	36 Months

EMERGENCY MEDICAL EVACUATION AND REPATRIATION OF REMAINS BENEFITS*

Emergency Medical Evacuation Benefit- We will pay up to the maximum indicated above in the Schedule of Benefits for your medical evacuation if you: 1) suffer a Medical Emergency during the course of the Trip; 2) require Emergency Medical Evacuation; and 3) are traveling on a covered Trip.

Covered Expenses include;

1) Medical Transport: expenses for transportation under medical supervision to a different hospital, treatment facility or to your place of residence for Medically Necessary treatment in the event of your Medical Emergency and upon the request of the Doctor designated by Our assistance provider in consultation with the local attending Doctor.

2) Dispatch of a Doctor or Specialist: the Doctor's or specialist's travel expenses and the medical services provided on location, if, based on the information available, your condition cannot be adequately assessed to evaluate the need for transport or evacuation and a doctor or specialist is dispatched by Our service provider to your location to make the assessment.

3) Return of Dependent Child (ren):expenses to return each Dependent child who is under age 18 to his or her principal residence if a) you are age 18 or older; and b) you are the only person traveling with the minor Dependent child(ren); and c) you suffer a Medical Emergency and must be confined in a Hospital.

4) Escort Services: expenses for an Immediate Family Member or companion who is traveling with you to join you during your emergency medical evacuation to a different hospital, treatment facility or your place of residence.

Benefits for these Covered Expenses will not be payable unless: 1) the Doctor ordering the Emergency Medical Evacuation certifies the severity of your Medical Emergency requires an Emergency Medical Evacuation; 2) all transportation arrangements made for the Emergency Medical Evacuation are by the most direct and economical conveyance and route possible; 3) the charges incurred are Medically Necessary and do not exceed the Usual and Customary Charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and 4) do not include charges that would not have been made if there were no insurance.

Benefits will not be payable unless We authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our assistance provider. In the event you refuse to be medically evacuated, we will not be liable for any medical expenses incurred after the date medical evacuation is recommended.

Repatriation of Remains Benefit

We will pay up to the maximum indicated above in the Schedule of Benefits for the preparation and return of your body to your home if you die as a result of a Medical Emergency while traveling on a covered Trip.

Covered expenses include: 1) expenses for embalming or cremation;2) the least costly coffin or receptacle adequate for transporting the remains; 3) transporting the remains; and 4) Escort Services which include expenses for an Immediate Family Member or companion who is traveling with you to join your body during the repatriation to your place of residence.

All transportation arrangements must be made by the most direct and economical route and conveyance possible and may not exceed the Usual and Customary Charges for similar transportation in the locality where the expense is incurred. Benefits will not be payable unless We authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our assistance provider

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS of $25,000**

Definition of Injury and Scope of Coverage – 24 Hour Coverage
Principal Sum for Covered Injury: $25,000

Accidental Death and Dismemberment Benefits - If your Injury results, within 365 days from 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. Principal Sum for you and your Dependents (if you have elected Dependent coverage and the required premium has been paid) is $25,000. If multiple losses occur, only one Benefit Amount, the largest, will be paid for all losses due to the same Covered Accident.

Schedule of Covered Losses

Covered Loss Benefit Amount

Life..... 100% of the Principal Sum

Two or more Members..... 100% of the Principal Sum

One Member..... 50% of the Principal Sum
“Member means Loss of Hand or Foot, and Loss of Sight. “Loss of Hand or Foot" means complete Severance through or above the wrist or ankle joint. “Loss of Sight” means the total, permanent Loss of Sight of one eye. Severance means the complete separation and dismemberment of the part from the body.

Aggregate Limit - We will not pay more than $125,000 for all losses. If, in the absence of this provision, We would pay more than this amount for all losses under the policy, then the benefits payable to each person with a valid claim will be reduced proportionately.

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 Description of Coverage is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the Policy issued to the Policyholder on Form # AH-15090. The Policy is subject to the laws of the state in which it is issued. Coverage may not be available in all states or certain terms or conditions may be different if required by state law. Please keep this information as a reference.

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). CHUBB maintains this insurance is short-term, limited duration insurance and is not subject to PPACA.

CHUBB 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.