The Insurance Company of the State of Pennsylvania

(Herein called the Company)

The Insurance Company of the State of Pennsylvania, herein referred to as "the Company" hereby insures all persons whose Application has been Approved, by Seven Corners, Inc., herein referred to as "the Administrator" on behalf of the Company and whose name is identified on the ID Card and/or recorded with the Administrator, subject to all of the Exclusions, Limitations and Provisions as set forth herein and in the Certificate of Insurance issued by the Company to the Policyholder. Coverage is afforded only with respect to the named Insured Person(s), Coverage, amounts and limits specified herein and as identified in the Schedule of Benefits for the Insurance requested on the Application and for which the specified Premium has been paid to the Administrator. Seven Corners, Inc. will provide the Claims and Assistance Services.

5 Star Worldwide Insurance

This document is a Program Summary outlining the full description in the 5 Star Worldwide Insurance Policy, Number GLB-9498605

Administrator
Seven Corners, Inc.
303 Congressional Blvd.
Carmel, IN 46032

Seven Corners Claims Office
800-335-0477 or 317-575-2656
Fax 317-575-2256 – claims@sevencorners.com

Seven Corners Assist
800-690-6295 or 317-818-2808
Fax 317-815-5984 – assist@sevencorners.com

Seven Corners Assist must be contacted:

- As soon as non-emergency hospitalization is recommended.
- Within 48 hours of the first working day following an emergency admission.
- When your physician recommends any surgery, including outpatient.
- For emergency evacuation, repatriation of remains and assistance services.

To obtain a list of U.S. providers, contact Seven Corners Assist or visit **www.sevencorners.com/PPO** for a list of providers. Use of Provider Network for this program is for convenience only and does not guarantee reimbursement or discounts.

ELIGIBILITY

Worker or any person and their dependents, over the age of 14 days who are traveling outside their Home Country, who have paid premium as outlined in the enrollment application, and who have completed the enrollment form in complete detail are eligible for 5 Star Worlwide Insurance. The Company maintains its right to investigate to verify that the eligibility requirements have been met. If and whenever the Company discovers that the eligibility requirements have not been met, its only obligation is refund of premium.

Dependents are Spouse and natural or legally adopted unmarried dependent children, stepchildren or foster children over 14 days and under 18 years of age.

EFFECTIVE DATE

Effective Date under the program shall become effective at 12:01 AM on the latest of the following dates:

1. The Insured Person's departure from his home country; or
2. The date the application and premium are received by the Administrator; or
3. The date requested on the application.

Dependent Child(ren) coverage will not be effective prior to that of the Named Insured.

EXPIRATION DATE

The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

1. The date shown on the insurance confirmation card, for which the premium is paid; or
2. The date the Insured Person returns to his Home Country(unless eligible for Home Country Coverage; or
3. 12 months after the Insured Person's original effective date; or
4. The date you are no longer eligible under this plan *See Home Country Coverage Section.

DEFINITIONS

"Certificate" shall mean the summary of the terms of Coverage, which includes this document, the Insured Person's Application and any endorsements or amendments that will attach during the Insured Person's Period of Coverage.
"Coverage Period" or **"Period of Coverage"** shall mean the period between the Individual Effective Date of Coverage and the Individual Termination Date of Coverage for this Certificate, which is stated on the Insured Person's ID Card.
"Covered Event" shall mean the Covered Expenses for an Illness or an Accidental bodily Injury necessitating medical Treatment by a Service Provider as defined in this Certificate.
"Covered Expenses" or **"Covered Medical Expenses"** shall mean expenses which are for Medically Necessary services, supplies, care, or Treatment; due to Illness or Injury, as described in the Certificate; prescribed, performed or ordered by a licensed Physician and/or Service Provider; Reasonable and Customary charges; incurred by the Insured Person during their Period of Coverage; and which are (1.) listed in the Schedule of Benefits, (2.) not excluded in the Exclusions and (3.) do not exceed the maximum limits stated in the Schedule of Benefits.
"Deductible" shall mean the amount of Eligible Benefits which are the responsibility of each Insured Person and must be paid by each Insured Person, before benefits under this Certificate are payable by the Company. The Deductible amount is stated on the ID Card and/or in the Schedule of Benefits.
"Dependent Child(ren)" means a Named Insured's dependent, unmarried children living with the Named Insured. This includes stepchildren, legally adopted children and children of adopting parents pending adoption procedures. Children shall cease to be dependent on the first to occur of: (1) the end of the month in which they marry; or (2) the end of the month in which they attain the age of nineteen (19) years. The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both: (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (2) chiefly dependent upon the Insured Person for support and maintenance. Proof of such incapacity and dependency shall be

furnished to the Company: 1) by the Named Insured; and 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company upon request following the child's attainment of the limiting age. If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsection (1) and (2).

"Eligible Benefits" shall mean expenses which are for Medically Necessary services, supplies, care, or Treatment; due to Illness or Injury; prescribed, performed or ordered by a licensed Physician and/or Service Provider; Reasonable and Customary charges; incurred by the Insured Person during their Period of Coverage; and which are (1.) listed in the Schedule of Benefits, (2.) not excluded in the Exclusions and (3.) do not exceed the maximum limits stated in the Schedule of Benefits.

"Emergency" shall mean a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger, if medical attention is not provided within 24 hours.

"Home Country" shall mean the country where an Insured Person has his or her true, fixed and permanent residence.

"Hospital" shall mean a place that 1.) is legally operated for the purpose of providing medical care and Treatment to Sick or Injured persons for which a charge is made that the Insured Person is legally obligated to pay in the absence of insurance 2.) provides such care and Treatment in medical, diagnostic, or surgical facilities on its premises, or those prearranged for its use; 3.) provides 24-hour nursing service under the supervision of a Registered Nurse at all times; and 4.) operates under the supervision of a staff of one or more Physicians. Hospital also means a place that is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals, American Osteopathic Association, or the Joint Commission on Accreditation of Heath Care Organizations (JCAHO). Hospital does not mean: -a Convalescent, nursing, or rest home or facility, or a home for the aged; -a place mainly providing Custodial, Educational, or Rehabilitative Care; or -a facility mainly used for the Treatment of drug addicts or alcoholics.

"Hospital Confined" or **"Hospital Confinement"** means confined in a Hospital for at least 18 hours by reason of an Injury or Sickness for which benefits are payable.

"Host Country" shall mean any country **other than** the country where an Insured Person has his or her true, fixed and permanent home and principal establishment.

"Injury" shall mean bodily Injury listed in the most recent edition of the International Classification of Diseases and caused solely and directly by Accidental, external, and visible means occurring while this Certificate is in force and resulting directly and independently of all other causes resulting in a Covered Event under this Program.

"Insured Person(s)" shall mean a person eligible for Coverage under the Certificate as stated on the ID Card, who has applied for Coverage and is named on the Application and for whom the Company has Approved for Coverage and accepted the corresponding Premium. This may be the Primary Insured Person or Dependent(s).

"Intensive Care or Coronary Unit" shall mean a cardiac care unit or other unit or area of a Hospital which meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

"Medical Emergency" means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in: (1) Death; (2) Permanent placement of the Insured's health in jeopardy; (3) Serious impairment of bodily functions; or (4) Serious and permanent dysfunction of any body organ or part. Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor injuries or minor Sicknesses.

"Medically Necessary or Medical Necessity" shall mean services, Treatment or supplies received by the Insured Person that are determined by the Company to be: 1.) appropriate and necessary for the symptoms, diagnosis, or direct care and Treatment of the Insured Person's medical conditions; 2.) within the standards the organized medical community deems good medical practice for the Insured Person's condition; 3.) not provided solely for educational purposes or primarily for the convenience of the Insured Person, the Insured Person's Physician or another Service Provider or person; 4.) not Experimental / Investigational and/or for Research; and 5.) not excessive in scope, duration, or intensity to provide safe and adequate, and appropriate Treatment. For Hospital stays, this means that acute care as an Inpatient is necessary due to the kinds of services the Insured Person is receiving or the severity of the Insured Person's condition, in that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The fact that any particular Physician may prescribe, order, recommend, or approve a service, Treatment, supply or level of care, does not of itself, make such Treatment Medically Necessary or make the charge a Covered Expense under this Certificate.

"Mental Illness" or **"Mental and Nervous Disorder"** shall mean Mental, emotional, and psychiatric disorders, Illnesses or conditions (whether organic or non-organic, whether biological, non-biological, genetic, chemical or non-chemical in origin). Mental and nervous disorders include, but are not limited to psychoses; neurotic disorders; bipolar disorders; affective disorders; personality disorders; psychological or behavioral abnormalities, associated with transient or permanent dysfunction of the brain or related neurohormonal systems; and disorders, conditions, and Illnesses listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders IV-R or the most recent edition of the International Classification of Diseases ICD-9-CM, which is the required reporting tool for all diagnoses and diseases to all U.S. Public Health Service and Health Care Financing Administration programs on the date the medical care or Treatment is rendered to an Insured Person.

"Physician" or **"Surgeon"** shall mean a doctor of medicine or a doctor of osteopathy licensed to render medical services or perform Surgery in accordance with the laws of the jurisdiction where such professional services are performed.

"Physiotherapy" shall mean physical therapy, recommended by a Physician for the treatment of a specific Covered Event and administered by a licensed physical therapist.

"Policyholder" means Global International Trust, Washington DC.

"Pre-Existing Condition" shall mean 1) A condition that would have caused a person to seek medical advice, diagnosis, care or Treatment within the 6 months (or 12 months for persons 70 and older) prior to the Individual Effective Date of Coverage under this program; 2) A condition for which medical advice, diagnosis, care or Treatment, including Medication, was sought, recommended or received within the 6 months (or 12 months for persons age 70 and older) prior to the Individual Effective Date of Coverage under this program; 3) the symptoms which occurred within the 6 months (or 12 months for persons 70 and older) prior to the Individual Effective Date of the Coverage under this Certificate would have allowed a person trained in medicine to make a diagnosis of the condition producing the symptoms: 4) a condition which manifested within the 6 months (or 12 months for persons 70 and older) prior to the Individual Effective Date of Coverage under this Certificate;

"Prescription Drugs" 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.

"Reasonable and Customary" shall mean the maximum amount that the Company determines is Reasonable and Customary for Eligible Benefits the Insured Person receives, up to but not to exceed charges actually billed. The Company's determination considers: 1.) amounts charged by other Service Providers for the same or similar service in the medical community where the services were received; 2.) any unusual medical circumstances requiring additional time, skill or experience; 3.) the cost to the Service Provider of providing the services or supplies or performing the procedure; and 4.) other factors the Company determines are relevant, including but not limited to, a resource based relative value scale.

For a Service Provider who has a reimbursement agreement with the Company, the Reasonable and Customary charge is equal to the amount that constitutes payment in full under any reimbursement agreement with the Company.

If a Service Provider accepts as full payment an amount less than the negotiated rate under a reimbursement agreement, the lesser amount will be the maximum Reasonable and Customary charge.

The Reasonable and Customary charge is reduced by any penalties for which a Service Provider is responsible as a result of that Service Provider's agreement with the Company.

"Service Provider" shall mean a Hospital, Hospice, Convalescent/skilled nursing facility, ambulatory surgical center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, alcohol or drug dependency treatment center, birthing center, Physician, Dentist,

chiropractor, licensed medical practitioner, nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility that the Company approves to provide services under the Certificate.
"Sickness" shall mean Illness or Disease of any kind listed in the most recent edition of the International Classification of Diseases. All related conditions and recurrent symptoms of the same or a similar condition will be considered one Sickness.
"Sound, Natural Teeth" means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed or defective.
"Treatment" shall mean medical or surgical management of a patient designed to resolve the Illness or Injury based on standard and accepted medical practice. For purposes of this Certificate, the course of action will only include those scheduled and approved benefits, for which the Insured Person is eligible.
"Usual and Customary Charges", see "Reasonable and Customary".

SCHEDULE OF BENEFITS

INJURY AND SICKNESS MEDICAL BENEFITS (PART A)
Maximum Benefit Limit Per Sickness or Injury:
Ages 14 days through 69: Options: $100,000 (Plan A) or $250,000 (Plan B) or $500,000 (Plan C)
Age 70 and over: $100,000
Deductible Per Person Per Sickness or Injury:
Ages 14 days through 69: Option $0, $50 or $100
Age 70 and over: $200.00
No Coinsurance applies.

	Plan A	**Plan B**	**Plan C**	**Age 70 and Over**
INPATIENT	**$100,000 Max per Injury/Sickness**	**$250,000 Max per Injury/Sickness**	**$500,000 Max per Injury/Sickness**	**$100,000 Max per Injury/Sickness**
Hospital Room & Board including miscellaneous	Up to $1400/day, 30 day max	Up to $1950 per day, 30 day max	Up to $3,000/day, 30 day max	Up to $1050/day, 30 day max
Hospital Intensive Care Unit	Additional $660/day, 8 day max	Additional $850/day, 8 day max	Additional $1,000/day, 8 day max	Additional $460/day, 8 day max
Surgical Treatment	Up to $3,300	Up to $5,500	Up to $10,000	Up to $2,750
Anesthetist	25% of surgical benefit	25% of surgical benefit	25% of surgical benefit	25% of surgical benefit
Assistant Surgeon	25% of surgical benefit	25% of surgical benefit	25% of surgical benefit	25% of surgical benefit
Physician's Non-Surgical Visits	Up to $55/visit, 1/day, 30 visits	Up to $85/visit, 1/day, 30 visits	Up to $125/visit, 1/day, 30 visits	Up to $55/visit, 1/day, 30 visits
A Consulting Physician, when requested by attending Physician	Up to $450	Up to $500	Up to $1,000	Up to $400
Private Duty Nurse	Up to $550	Up to $550	Up to $1,000	Up to $450
Pre-Admission Tests w/in 7 days before Hospital admission	Up to $1100	Up to $1100	Up to $3,000	Up to $775
OUTPATIENT				
Surgical Treatment	Up to $3,300	Up to $5,500	Up to $10,000	Up to $2,750
Anesthetist	25% of surgical benefit	25% of surgical benefit	25% of surgical benefit	25% of surgical benefit
Assistant Surgeon	25% of surgical benefit	25% of surgical benefit	25% of surgical benefit	25% of surgical benefit
Physician's Non-Surgical / Urgent Care Visits	Up to $55/visit, 1/day, 10 visits	Up to $85/visit, 1/day, 10 visits	Up to $125/visit, 1/day, 10 visits	Up to $55/visit, 1/day, 10 visits
Diagnostic X-rays & Lab Services	Up to $450 - Additional $250 - One Cat scan, PET scan or MRI	Up to $450 - Additional $250 - One Cat scan, PET scan or MRI	Up to $600 - Additional $400 - One Cat scan, PET scan or MRI	Up to $450 - Additional $250 - One Cat scan, PET scan or MRI
Hospital Emergency Room (all expenses incurred therein)	75% of U&C to a maximum of $330	75% of U&C to a maximum of $550	75% of U&C to a maximum of $750	75% of U&C to a maximum of $250
Prescription Drugs	Up to $100	Up to $150	Up to $300	Up to $80
Outpatient Surgical Facility	Up to $1000	Up to $1100	Up to $3,000	Up to $850
OTHER TREATMENT AND SERVICES				
Ambulance Services	Up to $450	Up to $450	Up to $1,000	Up to $450
Initial Orthopedic Prosthesis/brace	Up to $1100	Up to $1300	Up to $2,000	Up to $850
Chemotherapy and/or radiation therapy	Up to $1100	Up to $1350	Up to $2,500	Up to $850
Dental Treatment for Injury to Sound, Natural Teeth	Up to $550	Up to $550	Up to $750	Up to $550
Mental & Nervous Disorder & Substance Abuse	Same as any Sickness	Same as any Sickness	Same as any Sickness	Same as any Sickness
Physiotherapy	Up to $40/visit, 1/day, 12 visits	Up to $40/visit, 1/day, 12 visits	Up to $60/visit, 1/day, 12 visits	Up to $40/visit, 1/day, 12 visits
Emergency Evacuation	$100,000	$100,000	$250,000	$100,000
Return of Mortal Remains	$10,000	$10,000	$20,000	$10,000

Political Evacuation	$10,000	$10,000	$10,000	$10,000
AD&D Principal Sum	$25,000 Common Carrier	$25,000 Common Carrier	$25,000 Common Carrier	$25,000 Common Carrier
	Should an Insured Person turn 70 during the purchased coverage period, the 70 and over benefit schedule becomes effective upon the day the Insured Person turns 70.			

EMERGENCY EVACUATION AND REPATRIATION OF REMAINS (PART B)

BENEFIT	**MAXIMUM AMOUNT**
Emergency Evacuation	$100,000 maximum benefit
Return of Mortal Remains	$10,000 maximum benefit

COMMON CARRIER ACCIDENTAL DEATH & DISMEMBERMENT (PART C)

BENEFIT	**PRINCIPAL SUM**
Accidental Death & Dismemberment	$25,000

A. MEDICAL EXPENSE BENEFITS – INJURY AND SICKNESS

When a covered Injury or Sickness requires treatment by a Physician, this program will provide benefits for the Usual and Customary Charges for Medically Necessary Covered Medical Expenses which exceed the deductible per person for each Injury or Sickness and which are incurred within **26 weeks following the Injury or Sickness**. Payment for any Covered Medical Expense will be no more than the Benefit Limit shown for it in the Schedule of Benefits. The total payable for all Covered Medical Expenses will be no more than the Maximum Benefit Limit per Sickness or Injury. Benefits are subject to the Excess Benefits Provision.

If a benefit is designated in the Schedule of Benefits, Covered Medical Expenses include:

1) Charges made by a Hospital for room and board, floor nursing and other services inclusive of charges for professional services and (with the exception of personal services of a non-medical nature; charges made for an operating room.
2) Charges made for Intensive Care of Coronary Care charges and nursing services.
3) Hospital Miscellaneous Expenses: 1) while Hospital Confined; or 2) for pre-admission expenses for being Hospital Confined. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; x-ray examination; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies.
4) Charges for physiotherapy, if recommended by a Physician for the treatment of a specific Injury and administered by a licensed physiotherapist (inpatient).
5) Charges made for diagnosis, treatment and Surgery by a Physician for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. Covered medical expenses will be paid under this inpatient surgery benefit; or under the outpatient surgery benefit, but not for both.
6) Charges made for the cost and administration of anesthetics: in connection with inpatient surgery.
7) Private Duty Nurse's Services: 1) private duty nursing care only; 2) while Hospital Confined; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.
8) Physician's Visits: when Hospital Confined. Benefits are limited to one Physician's visit per day. Benefits do not apply when related to surgery. Covered medical expenses will be paid under the inpatient benefit or under the outpatient benefit for Physician's Visits but not both.
9) Pre-admission Testing: limited to routine tests such as: complete blood count; urinalysis; and chest x-ray. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit.
10) Mental and Nervous Disorder (inpatient): the benefits and the maximum amounts are specified in the Schedule of Benefits. Benefits are limited to one Physician's visit per day.
11) Charges made for diagnosis, treatment and Surgery by a Physician for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. Covered medical expenses will be paid under this outpatient surgery benefit; or under the inpatient surgery benefit, but not both.
12) Day Surgery Miscellaneous (Outpatient Surgical Facility): in connection with outpatient day surgery; excluding non-scheduled surgery, and surgery performed in a Hospital emergency room, trauma center, Physician's office, or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room, laboratory tests and x-ray examinations including professional fees, anesthesia, drugs or medicines, therapeutic services and supplies.
13) Anesthetist (Outpatient): in connection with outpatient surgery.
14) Physician's Visits (Outpatient): Includes injections administered during visit. Benefits do not apply when related to surgery or Physiotherapy. Covered medical expenses will be paid under the outpatient benefit or under the inpatient benefit for Physician's visits but not both.
15) Medical Emergency Expenses (Outpatient): only in connection with a Medical Emergency as defined. Benefits will be paid for the use of the emergency room and supplies.
16) Radiation Therapy (Outpatient)
17) Chemotherapy (Outpatient)
18) Prescription Drugs (Outpatient)
19) Mental and Nervous Disorder (Outpatient): the benefits and the maximum amounts are specified in the Schedule of Benefits. Benefits are limited to one Physician's visit per day.
20) Ground ambulance (within the metropolitan area) to and from the nearest Hospital with facilities for required treatment. If the Insured Person is in a rural area, then licensed group ambulance transportation to the nearest metropolitan area shall be considered.
21) Braces and Appliances: 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Replacement braces and appliances are not covered. Braces and appliances 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. No benefits will be paid for rental charges in excess of purchase price.
22) Consultant Physician Fees: when requested and approved by the attending Physician.
23) Dental Treatment: 1) performed by a Physician; and 2) made necessary by Injury to Sound, Natural Teeth. Routine dental care and treatment to the gums are not covered.
24) Alcoholism/Drug Abuse Treatment: the benefits and the maximum amounts are specified in the Schedule of Benefits.

B. EMERGENCY EVACUATION

The Company shall pay benefits for Covered Expenses incurred up to $100,000, if any covered Injury or Illness commencing during the Period of Coverage results in the Medically Necessary Emergency Medical Evacuation or Repatriation of the Insured Person. The Emergency Medical Evacuation or Repatriation must be ordered by the Assistance Company in consultation with the Insured Person's local attending Physician.

Emergency Medical Evacuation or Repatriation means: a) the Insured Person's medical condition warrants immediate transportation from the place where the Insured Person is located to the nearest adequate medical facility where medical treatment can be obtained; or b) after being treated at a local medical facility as a result of a Emergency Medical Evacuation, the Insured Person's medical condition warrants transportation with a qualified medical attendant to his/her Home Country to obtain further medical treatment or to recover; or c) both a) and b) above. All transportation arrangements must be by the most direct and economical route and be performed by the Assistance Service Provider.

C. RETURN OF MORTAL REMAINS

The Company will pay the reasonable Covered Expenses incurred up to $10,000 to return the Insured Person's remains to his/her Home Country, if he or she dies. Covered Expenses include, but are not limited to, expenses for embalming, [a minimally necessary container appropriate for transportation, shipping costs, and the necessary government authorizations.] The Assistance Service Provider must perform all transportation arrangements.

D. POLIITICAL EVACUATION

If due to political or military events in a host country, a formal recommendation from the appropriate authorities is issued for the insured to leave the host country or the insured is expelled or declared persona non-grata by the host country, all reasonable expenses incurred for the transportation to the nearest place of safety or for repatriation to the insured's home country or country of residence are covered up to a maximum of $10,000. Evacuation must occur within 10 days of any such event. Coverage will apply to the most appropriate and economical means consistent under the circumstances with your health & safety. Evacuation costs will be paid once per insured per occurrence. In the event this benefit is needed, the Assistance Service Provider must make arrangements.

E. COMMON CARRIER ACCIDENTAL DEATH AND DISMEMBERMENT INDEMNITY

Accidental Death & Dismemberment Coverage shall apply only to covered accidents sustained by an Insured Person:

1. while riding as a passenger (but not as a pilot, operator or member of the crew) in or on (including getting in or out of, or on or off of):
   A) any land, water or air conveyance operated under a license for the transportation of passengers for hire; or
   B) any Military Air Transport Aircraft; or
2. by being struck down by any aircraft.

The Company shall pay an indemnity determined from the Table of Losses below if an Insured Person sustains a loss stated therein resulting from Injury, provided that:

(a) such loss occurs within 365 days after the date of accident causing such loss; or

(b) the indemnity payable for any such loss shall be the amount stated opposite such loss in said Table and the Principal Sum stated therein shall be the amount stated in the Schedule of Benefits, as applicable to such person and this Coverage; and

(c) if more than one loss stated in said Table is sustained as the result of one accident, only one of the amounts so stated in said Table, the largest, shall be payable.

For Loss of:	**Indemnity**
Life	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
Either Hand or Foot and Sight of One Eye	Principal Sum
Either Hand or Foot	One-Half the Principal Sum
Sight of One Eye	One-Half the Principal Sum

The term "loss" as used herein shall mean with regard to hands and feet, actual severance through or above wrist or ankle joints, and with regard to eyes, entire irrecoverable loss of sight.

F. AGGREGATE LIMIT OF INDEMNITY

The Aggregate Limit of Indemnity of $125,000 shall be the total limit of the Company's liability for all indemnities payable under Accidental Death and Dismemberment Indemnity with respect to all classes of Insured Persons arising out of Injury sustained by two or more Insured Persons as the result of any one accident.

If the total of such indemnity exceeds said Aggregate Limit of Indemnity, the Company shall not be liable to any one such Insured Person for a greater proportion of such Insured Person's Indemnity afforded by the Accidental Death and Dismemberment Indemnity than said Aggregate Limit of Indemnity bears to the total Indemnities afforded by this Accident Death and Dismemberment Indemnity to all such Insured Persons.

G. HOME COUNTRY COVERAGE

Incidental Trips to Your Home Country: This benefit covers you for incidental trips to your Home Country (90 days per 12 months of purchased coverage or pro rata thereof, which is 7.5 days per month of purchased coverage). Maximum benefit is reduced to $50,000 for any illness or injury initially diagnosed while on an incidental trip to your Home Country. Follow Me Home Coverage: This plan shall pay for Covered Expenses incurred in your Home Country only up to $5,000 for conditions initially diagnosed while outside Your Home Country (Does not apply for Emergency Evacuation).

H. PERIOD OF COVERAGE

An Eligible Person may enroll for a period of coverage ranging from 5 days to 12 months, subject to the following rules: Five days premium is the minimum acceptable premium; twelve month's premium is the maximum acceptable premium; and the full premium is payable at the time of enrollment.

I. RENEWAL

5 Star Worldwide Insurance provides you with two options to renew and continue your coverage in any increment you choose (Minimum 5 day purchase). There is a $5 administration fee each time you renew.

Renewal Option 1

If you initially purchased 5 Star Worldwide Insurance, Seven Corners will e-mail you renewal notices prior to your expiration date, if you do not respond to the e-mailed renewal notice Seven Corners will assume that you no longer require the coverage and will not send another renewal notice.

Renewal Option 2

We understand access to the Internet and e-mail is not always possible in the field. So, if you initially purchased 5 Star Worldwide Insurance by completing and mailing or faxing a paper application and payment to Seven Corners, Inc., you will be notified by Seven Corners, Inc. prior to your renewal. This option is not as reliable as applying on-line and may take more time for you to respond to a renewal offer. Thus, we recommend that in order to allow for adequate time to contact you, you at least purchase 3 months of coverage for each renewal period. If Seven Corners, Inc. is unable to contact you prior to your renewal; your coverage will terminate. Please contact Seven Corners, Inc. for more information on this option.

The maximum number of months during any one period for 5 Star Worldwide Insurance cannot exceed 12 months. The 5 Star Worldwide Insurance Plan can be renewed as many times as you wish, as long as you meet the Eligibility requirements of the plan. Upon each renewal, the program rates and benefits are subject to change.

J. REFUND PROCEDURE

Refunds are given only if written request is received by the Company or its authorized administrator prior to an Insured's effective date of coverage. After an Insured's effective date, the premium is considered fully earned and non-refundable.

K. EXCLUSIONS AND LIMITATIONS

No benefits will be paid for loss or expense caused by, contributed to, or resulting from:

1) Pre-Existing Conditions;
2) No benefits will be paid for loss or expense caused by, contributed to, or resulting any loss that occurs while traveling or enrolling solely for the purpose of obtaining medical treatment, while on a waiting list for a specific treatment, or while traveling against the advice of a Physician;
3) Expense incurred within the Insured Person's Home Country or country of regular domicile;
4) Routine physical or other examinations where there are no objective indications of impairment of normal health, or well baby care;
5) Eye examinations; prescriptions or fitting of eyeglasses and contact lenses; or other treatment for visual defects and problems. "Visual Defects" means any physical defect of the eye which does or can impair normal vision;
6) Hearing examinations 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;
7) Dental treatment, except as the result of Injury to Sound, Natural Teeth as stated in the Schedule of Benefits;
8) Professional services rendered by a member of the Insured Person's immediate family, or anyone who lives with the Insured Person;
9) Services or supplies not necessary for the medical care of the patient's Injury or Sickness,
10) Weak, strained or flat feet, corns, calluses, or toenails;
11) Cosmetic surgery, or treatment for congenital anomalies (except as specifically provided), except reconstructive surgery 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;
12) Elective surgery and elective treatment;
13) Diagnostic or surgical procedures in connection with infertility unless infertility is a result of a covered Injury or Sickness;
14) Birth control, including surgical procedures and devices;
15) Routine new-born baby care, well-baby nursery and related Physician charges;
16) Participation in professional or intercollegiate athletics;
17) Injury or Sickness for which benefits are paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation;
18) Organ transplants;
19) War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered);
20) Participation on a riot or civil disorder; commission of or attempt to commit a felony in the country in which it was attempted or committed;
21) Suicide or attempted suicide (including drug overdose) while sane or insane (while sane in Missouri); or intentionally self-inflicted Injury;
22) Charges of an institution, health service, or infirmary for whose service payment is not required in the absence of insurance;
23) Treatment of nervous or mental disorders, except as stated in the Schedule of Benefits, or treatment of alcoholism or drug abuse, except as provided for treatment of mental or nervous disorders, according to the Schedule of Benefits;
24) Loss incurred from riding in any aircraft, other than as a passenger in an aircraft licensed for the transportation of passengers;
25) Treatment, services, supplies or facilities in a Hospital owned or operated by: a) 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 is required by law to pay);
26) Duplicate services actually provided by both a certified nurse-midwife and Physician;
27) Expenses payable under any prior policy which was in force for the person making the claim;
28) Expenses incurred during a Hospital emergency room visit which is not of an emergency nature;
29) Expenses incurred for 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 vertebral column;
30) Medical expense resulting from a motor vehicle accident in excess of that which is payable under any valid and collectible insurance;
31) Voluntary or elective abortion;
32) Expenses covered by any other valid and collectible medical, health or accident insurance;
33) Expenses incurred after the date insurance terminates for an Insured Person except as may be specifically provided;
34) Expenses incurred for injuries resulting from the use of alcohol or intoxicants, or any drugs unless prescribed by a Physician;
35) Sexually transmitted disease, including AIDS.

THERE ARE NO BENEFITS PROVIDED FOR THE FOLLOWING:

Elective Surgery and Elective Treatment: including but is not limited to surgery and/or treatment for acne; acupuncture; allergy; including allergy testing; alopecia; biofeedback-type services; birth control; breast implants; breast reduction; circumcision; corns, calluses and bunions; cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under the policy; family planning; fertility tests; gynecomatia; hirsutism; impotence, organic or otherwise; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; learning disabilities; nasal and sinus surgery; nicotine addition; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia of any kind); patient controlled anesthesia treatment of a covered Injury; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including testing thereof; temporomandibular joint dysfunction, tubal ligation; vasectomy; and weight reduction. Elective surgery and elective treatment includes any service, treatment; or supplies that: 1) are deemed by the company to be researched or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

GENERAL PROVISIONS

1. Entire Contract; Changes: The Certificate, including the Application, Schedule of Benefits, endorsements and the attached papers, if any, constitutes the entire contract of Insurance. No change in the Certificate shall be valid until approved by an executive officer of the Company and unless such approval is endorsed hereon. No agent has authority to change this Certificate or to waive any of its provisions;
2. Notice of Claim: Written notice of claim must be given to the Company within ninety (90) days after the occurrence or commencement of any Disablement covered by the Certificate, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Seven Corners, Inc. (Seven Corners), or to any authorized agent of the Company, with information sufficient to identify the Insured Person shall be deemed notice to the Company.

3. Claim Forms: The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the 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 Disablement for which claim is made.
4. Proof of Loss: Written Proof of Loss, which will include, but not limited to: original signed and dated claim form, original receipts and bills, copies of medical records; must be furnished to Seven Corners, Inc. (Seven Corners), at its said office, within ninety (90) days after the date of such Disablement. 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.
5. Payment of Claims: Subject to any written direction of the Insured Person all or a portion of any indemnities provided by this Certificate on account of Hospital, nursing, medical or Surgical service may, at the Company's option and unless the Insured Person requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the Hospital or person rendering such services.
6. Physical Examination and Autopsy: The Company at its own expenses shall have the right and opportunity to examine the person of any individual whose Injury or Illness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.
7. Legal Actions: Any disputes arising from this Certificate, or its alleged breach, may, if not resolved by the parties, be referred to arbitration by either party. Arbitration shall be conducted in the City of Carmel, Indiana, USA in accordance with Commercial Arbitration Rules of the American Arbitration Association, and judgment on any award rendered in such arbitration may be entered in any state or federal court in such City. Arbitration shall be the sole remedy for alleged breach of this Certificate. Notices in connection with such arbitration and process in any judicial proceeding in connection wherewith may be served by personal delivery or registered mail on the Company at its international administrators office of 303 Congressional Boulevard, Carmel, Indiana 46032 USA and on the Insured Person at the most current address appearing on the records of the Company, with the same effect as if personally served in such City. The Company's liability in any such arbitration shall be limited to such amounts as the arbitrators may determine are due under this Certificate, with such interest thereon and such cost of the arbitration proceeding, if any, as the arbitrators may direct. In no event shall the Company be liable for any extra-contractual damages, whether characterized, without limitation, as consequential, exemplary, punitive or tort damages, for any alleged breach of this Certificate.
   No actions at law or in equity shall be brought to recover on the Certificate prior to the expiration of sixty (60) days after written Proof of Loss has been furnished in accordance with requirements of this Certificate. No such action shall be brought after expiration of twelve (12) months after the time that written Proof of Loss is required to be furnished.
8. Grace Period: There is no Grace Period associated with this program.
9. Cancellation: The Certificate is renewable for up to a total period of 12 months. The Company may cancel an entire class of Insured Persons based upon claims experience in a certain region or within a gender / age category.
10. Not in Lieu of Worker's Compensation: This Insurance is not in lieu of and does not affect any requirements for coverage by Worker's Compensation Insurance.
11. Certificate of Insurance: The Company shall issue to each Insured Person an individual Program Summary (Certificate of Insurance), which shall state the essential features of Insurance to which such person is entitled and to whom benefits are payable, if required to do so by the laws of the locality in which the Insured Person resides when his Insurance becomes effective.
12. Data Furnished by Insured Person(s): Insured Person shall furnish all information requested on the Application and any additional information requested by the Company.

    The refusal of the Insured Person, the Insured Person's Physician, Hospital or Service Provider to make all medical reports and records available to the Company could cause an otherwise valid claim or Application to be denied or the file to be closed due to lack of or limited reply from the Insured Person's medical providers.

    Failure on the part of the Insured Person to maintain adequate documentation regarding travel history could cause an otherwise valid claim (where travel history is material to the benefit and claim) to be denied or the file to be closed.

    The Company has the option whether or not to consider medical information provided by friends / relatives of the Insured Person as valid for underwriting or claim administration.

13. Assignment: The Insurance provided hereunder is not assignable, but benefits may be assigned in accordance with #5, Payment of Claims.
14. Excess Benefits: All coverages shall be in excess of all other valid and collectible insurance and shall apply only when such benefits are exhausted.
    Other valid and collectible insurance for which benefits may be payable are insurance programs provided by:
    1.) Individual, group or blanket insurance or coverage;
    2.) Other prepayment coverage provided on a group or individual basis;
    3.) Any coverage under labor management trusteed plans, union welfare plans, employer organizational plans, employee benefit organization plans, or other arrangement of benefits for individuals of a group;
    4.) Any coverage required or provided by any statute, socialized insurance program; or
    5.) Any no-fault automobile insurance;
    6.) Any third party liability insurance.
15. Monetary Limits: The monetary limits stated in this Certificate and the premium shall be in United States dollars. For services outside of the territorial limits of the United States, the exchange rate used to determine the amount of United States dollars to be paid is the exchange rate effective for the date the claims expense was incurred.
16. Subrogation: The Certificate has the right to full subrogation and reimbursement of any and all amounts paid by the Certificate to or on behalf of, an Insured Person, if the Insured person receives any sum of money from any person, plan or legal entity which is legally obligated to make payments arising out of any act or omission of any person whether a third party or another covered person under the Certificate, which directly or indirectly caused a physical or mental condition, in connection with which payment of any benefits under the Certificate to, or on behalf of, such Insured Person was made. The Certificate shall have a lien against such sum of money received from third parties or other persons described above or their insurers, or the insurer of the Insured Person, and shall be reimbursed therefrom. The Insured Person further agrees to notify other persons described above in writing, of the Certificate's subrogation and lien rights before the receipt of any payment from said parties or other persons.

    The Insured Person shall be responsible for all expenses of recovery from such parties or other persons, including but not limited to, all attorneys' fees incurred in collection of such payments or payments by other persons, which fees and expenses shall not reduce the amount of reimbursement to the Certificate required of the Insured Person. The Insured Person agrees to reimburse the Certificate for any benefit paid hereunder, out of any monies recovered from such party or other persons as a result of judgment, settlement or otherwise, even though such monies are not characterized as amounts paid for medical expenses or claims. The Insured Person agrees to furnish such information and assistance, and to execute and deliver all necessary instruments, as the Company or its designee may request to facilitate the enforcement of these subrogation rights, including but not limited to the execution of a subrogation agreement prior to payments of benefits under the Certificate to, or on behalf of the Insured Person.

The Insured Person shall not release or discharge any party from his or her obligation to the Insured Person or the Certificate or take any other action which could impair the Certificate's subrogation rights. The Certificate's exercise of its rights to take whatever action it sees fit against any third party or other persons shall not affect the Insured Person's right to pursue other forms of recovery.

If the Insured Person or any one acting on his or her behalf has not taken action to push his or her rights against such parties or other persons to obtain a judgment, settlement or other recovery, the Company or its designee, upon giving thirty (30) days written notice to the Insured Person shall have the right to take such action in the name of the Insured Person to recover that amount of benefits paid under the Certificate; provided, however, that any action taken without the consent of the Insured Person shall be without prejudice to such Insured Person.

The Certificate's right to reimbursement as set forth herein shall be payable first from sums received from the parties or other persons and such reimbursement shall continue until the Insured Person's obligations hereunder to the Certificate are fully discharges, even though the Insured Person does not receive full compensation or recovery for his/her injuries, damages loss or debt. This right to subrogation pro tanto shall exist in all cases.

If an Insured Person fails to comply with these requirements, the Insured Person shall not be eligible to receive any benefits, services or payments under the Certificate until there is compliance regardless of whether such benefits are related to the act or omission of such party or other persons.

17. Fraud and Misrepresentation: Any misstatement, concealment or fraud in the Applicant's (or Applicant's authorized representative) statements, either on the Application or on subsequent contact (including any claim submissions), whether in writing or otherwise, to the Company or its representatives, shall render this insurance null and void and all claims hereunder shall be forfeited. In addition, if any fraudulent means or devices are used by any Insured Person (or Applicant) or anyone acting on their behalf, this insurance shall be null and void and all claims hereunder shall be forfeited.

How to obtain travel assistance

To receive assistance worldwide, call Seven Corners Assist at the numbers below and provide them with your ID Number.
For Emergency Medical Evacuation, Return of Remains, Assistance Services, call:
if in the United States or Canada: 1-800-690-6295 or if outside the United States or Canada: 1-317-818-2808 (collect)

Claims Services

Important Note: Claim forms and receipts for medical expenses must be sent to Seven Corners quickly. Claim submissions must be made within 90 (ninety) after the Date of Service. Should they be received after 90 (ninety) days, they may be considered ineligible.

To report claims or verify eligibility, send the original bills and claim forms to Seven Corners, Inc. or call or fax to the numbers below. Be certain to include your ID# shown on the ID Card with all correspondences:
Seven Corners, Inc.
303 Congressional Blvd., Carmel, IN 46032
800-335-0477 or 317-575-2256 FAX 317-575-2659 email: info@sevencorners.com www.sevencorners.com

Insurance Company

This Insurance, under Policy GLB-9498605, is underwritten by**:** The Insurance Company of the State of Pennsylvania, with its principal place of business in New York, NY, is a member of Chartis which is highly rated for financial strength.