



# Camp America Master Policy

In consideration of the payment of required premium, the Company agrees with the Policyholder named in the Declarations (herein called Policyholder) to insure eligible persons of the Policyholder (herein individually called Insured Person), to the extent herein provided and subject to all of the exceptions, limitations and provisions of the Policy.

## DECLARATIONS

Name of Policyholder: Camp America and Resort America

Address: 37 Queen's Gate  
London SW7 SHR United Kingdom

Policy Effective Date: January 1, 2010  
Policy Expiration Date: December 31, 2010

Insurer: ACE European Group Limited  
Direktion für Deutschland  
Lurgiallee 10  
60439 Frankfurt

ACE Policy Number 58 GE 752 172

Eligible of Persons: The following persons shall be eligible for insurance hereunder:

Class Description of Class

- I Individuals up to age 40 of the Policyholder enrolled under an Sponsored Program of the Policyholder as described hereunder
- II Individuals over age 40 of the Policyholder enrolled under an Sponsored Program of the Policyholder as described hereunder
- III Individuals over age 60 of the Policyholder enrolled under an Sponsored Program of the Policyholder as described hereunder

Sponsored Program: A program sponsored by the Participating Organization including without limitation programmes known as Camp America and Resort America



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## PART I

### ELIGIBILITY, EFFECTIVE AND TERMINATION PROVISIONS

#### Eligibility:

Each person who belongs to one of the Descriptions of Class set forth in the Declarations is eligible to be insured under this policy. The Company maintains its right to investigate to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

#### When an Insured's Coverage Begins:

Coverage will become effective for an Eligible Participant on the later of the following dates but not before May 1st of the policy year:

- a) The Effective Date of the Master Policy; or
- b) The date requested by the Insured for coverage to begin; or
- c) The commencement of the Insured's outbound flight from their Home Country;

#### When an Insured's Coverage Ends:

Coverage will terminate for an Insured on the earliest of the following dates:

- a) The return of the Insured to their Home Country; either upon disembarkment from the Insured's Sponsoring Program's return flight home, or departure from the United States if the Insured has provided the Insured's own transportation.
- b) 153 days from the Effective Date;
- c) 31 October of the policy year;
- d) The Policy Expiration Date;
- e) The date requested by the Insured for coverage to end;
- f) The date through which premium has been paid for;
- g) The Effective Date of Coverage if the Insured Person fails to show up at the camp;
- h) The Insured's termination either voluntary or involuntary from the Sponsored Program;
- i) The date the Insured ceases to meet the Eligibility Requirements



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## PART II

### DEFINITIONS

"Accident" or "Accidental" shall mean an event, independent of Illness or self inflicted means, which is the direct cause of bodily Injury to an Insured Person.

"Assistance Company" shall mean Cultural Insurance Services International (CISI), 9 West Broad Street, Stamford, CT 06902, acting as agent on behalf the Company

"Benefits" shall mean Covered Expenses, Death/Dismemberment Benefits, Unexpected Recurrence of Pre-Existing Condition Benefits, Programme Termination Transportation Expenses and, if selected by the Insured Person prior to the Effective Date, Personal Effects cover. For the avoidance of doubt, Benefits shall exclude, and the Company shall have no liability in respect of, Excluded Expenses.

"Benefit Period" shall mean the allowable time period from the commencement of Illness or the onset of Injury, where such commencement or onset arises during the Period of Coverage, for the Insured Person to receive Diagnosis or Treatment which gives rise to a Covered Expense. The Company shall have no liability in respect of: (i) any such Illness or Injury which continues or recurs after the Benefit Period; or (ii) where the Diagnosis or Treatment in respect of any such Injury or Illness continues, occurs or recurs after the Benefit Period.

"Coinsurance" shall mean the percentage amount of Covered Expenses, after the Deductible, which is the responsibility of the Insured Person and must be paid by the Insured Person. The Coinsurance amount is stated in the Schedule of Benefits.

"Company" shall be ACE European Group Limited ("ACE") registered in England No. 111 2892, FSA register number: 473510.

"Computer" shall mean personal computers (including laptop or palmtop-sized computer)

"Covered Expenses" shall mean expenses which are for Medically Necessary services, supplies, care, or treatment; due to Illness or Injury; prescribed, performed or ordered by a Physician; Reasonable and Customary charges; incurred while insured under this Policy; and which do not exceed the maximum limits shown in the Schedule of Benefits, under each stated benefit. Covered Expenses shall include expenses for transportation, medical services and medical supplies necessarily incurred in connection with an Emergency Medical Evacuation or Repatriation of the Insured Person.

"Death/Dismemberment Loss" shall mean an Injury (but not an Illness, except any pyogenic infection which shall occur through an accidental cut or wound) which results in the loss of life or body part or function listed in the Accidental Death and Disablement description of loss table below.

"Deductible" shall mean the amount of eligible Covered Expenses which are the responsibility of each Insured Person and must be paid by each Insured Person before benefits under the Policy are payable by the Company. The Deductible amount is stated in the Schedule of Benefits, under each stated benefit.

"Dental Diagnosis or Treatment" shall mean Diagnosis or Treatment in respect of teeth or gums, but only to the extent such Diagnosis or Treatment is limited to:

- (a) the initial emergency repair or replacement of sound, natural teeth which have suffered an Injury, and/or



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- (b) the alleviation of pain resulting from an Illness or Injury (including the infection of) gums or sound natural teeth.

"Diagnosis" shall mean the examination, investigation, analysis or assessment of an Illness or Injury for the purposes of deciding on its Treatment; advice from a Physician in respect of such examination, investigation, analysis or assessment is also Diagnosis; for the avoidance of doubt, Diagnosis shall include psychiatric evaluation as part of the Diagnosis of a Mental and Nervous Disorder, but exclude psychotherapy.

"Disablement" shall mean an Illness or an Accidental bodily Injury necessitating medical treatment by a Physician as defined in this Policy.

"Effective Date" shall mean the date the Insured's Persons coverage under this Policy begins. The Effective Date is the later of the following:

- a) The Effective Date of the Master Policy; or
- b) The date requested by the Insured for coverage to begin; or
- c) The commencement of the Insured's outbound flight from their Home Country;

"Elective Treatment" means Treatment (including, for the avoidance of doubt, surgery) which is not Medically Necessary. Elective Treatment includes, but is not limited to:

- a) Treatment of cosmetic conditions (which includes plastic surgery), except where prescribed by a Physician consequent to an Illness or Injury sustained by the Insured Person; for the purposes of this policy a deviated nasal septum shall be considered a cosmetic condition;
- b) circumcision, tubal ligation, vasectomy, breast reduction, sexual reassignment surgery;
- c) sub mucous resection and/or other surgical correction for deviated nasal septum, other than for the Medically Necessary Treatment of covered purulent sinusitis.

"Electronic Devices" shall mean personal (including any device which is handheld or pocket-sized) electronic communication (including mobile telephone), data and entertainment (including audio and visual entertainment, including with respect to music, games or video) storage, transmission or presentation devices.

"Eligible Benefits" shall mean benefits payable by the Company to reimburse expenses which are for Medically Necessary services, supplies, care, or treatment; due to Illness or Injury; prescribed, performed or ordered by a Physician; Reasonable and Customary charges; incurred while insured under this Policy; and which do not exceed the maximum limits shown in the Schedule of Benefits under each stated benefit.

"Emergency" shall mean an Injury or Illness which manifests itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if Treatment is not provided within 24 hours.

"Emergency Medical Evacuation" or "Repatriation" shall mean, in the event of an Emergency:

- a) the Insured Person's Illness or Injury warrants immediate transportation from the place where the Insured Person is located (due to appropriate Treatment being unavailable) to the nearest Hospital or other medical facility which can provide appropriate Treatment; or
- b) after being treated at a Hospital or other local medical facility, the Insured Person's Illness or Injury warrants transportation with a Physician, nurse or other qualified medical attendant to his/her Home Country to obtain further Treatment; or
- c) both (a) and (b) above.



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"Expenses" means charges, costs, expenses or liability directly relating to such charge cost or expense.

"Family Member" shall mean a spouse, parent, sibling or Child of the Insured Person.

"Home Country" shall mean the country where an Insured Person is domiciled.

"Hospital" shall mean except as may otherwise be provided, a place that operates pursuant to law for Treatment of sick or Injured persons with organized facilities for Diagnosis and Treatment (including, for the avoidance of doubt, surgery) and having 24-hour nursing service and medical supervision, that is:

- a) legally operated for the purpose of providing 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;
- b) provides such care and treatment in medical, diagnostic, or surgical facilities on its premises, or those prearranged for its use;
- c) provides 24-hour nursing service under the supervision of a registered nurse at all times; and
- d) operates under the supervision of a staff of one or more doctors.

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 Health Care Organizations (JCAHO).

Hospital does not mean:

- a) a convalescent, nursing, or rest home or facility, or a home for the aged;
- b) a place mainly providing custodial, educational or rehabilitative care; or
- c) a facility mainly used for the Treatment of drug addicts or alcoholics.

"Illness" shall mean sickness or disease of any kind which gives rise to any pathological or traumatic change to any part of the body, and which sickness or disease was contracted, and which change occurred and was manifested (including by any symptom), during the Period of Coverage; Illness shall include any such sickness or disease materially resulting from an Injury

"Injury" wherever used in this Policy shall mean bodily Injury caused solely and directly by violent, Accidental, external, and visible means occurring while this Policy is in force and resulting directly and independently of all other causes in Disablement covered by this Policy.

"Insured Person" shall mean a person described as eligible as defined in part 1 above, who has applied for coverage and in respect of whom the Company has accepted premium. In the event of a claim by an Insured Person, all references in this Policy to an Insured Person are to the Insured Person bringing such claim.

"Medically Necessary" or "Medical Necessity" shall mean Diagnosis or Treatment (including Emergency Evacuation/Repatriation as set out in section 6 below) in consequence of an Illness or Injury sustained by the Insured Person where such Diagnosis or Treatment is prescribed or undertaken by a Physician (or by any other person for whom it was necessary in the circumstances of or surrounding the Insured Person's sustaining or manifesting the said Illness or Injury to undertake Diagnosis or Treatment), provided that:

- a) the Illness or Injury does or did not arise in whole or in part from an Excluded Occurrence or Excluded Condition, or does or did not constitute a manifestation (including a symptom) of an Excluded Condition; and
- b) the Diagnosis or Treatment is



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- i. within standards which the organized medical community in the US would, in the circumstances of or surrounding the Illness, Injury, Diagnosis or Treatment) deem reasonable, including in term of scope, duration, or intensity of Diagnosis or Treatment so as not to give rise to the risk of different or additional Illness or Injury;
- ii. not primarily for the convenience or material or reputational gain of the Insured Person, the Insured Person's Physician or another service provider or person; and
- iii. not otherwise excluded by the terms of this Policy.

"Medical Maximum" shall mean the maximum amount of cover available as explained in the Schedule of Benefits per Eligible Person.

"Mental and Nervous Disorder" shall mean an Illness that is a mental, emotional or behavioral disorder (including neurosis, psychoneurosis, psychopathy, or psychosis).

"Participating Organisation" is The American Institute for Foreign Study UK Ltd - Camp America and Resort America.

"Period of Coverage" shall mean the Insured's policy period commencing with the Insured's Effective Date and ending with the Insured's Expiration Date as defined hereunder.

"Permanent Residence" shall mean the country where an Insured Person has his or her true, fixed and permanent home and principal establishment, and to which he or she has the intention of returning.

"Personal Effects" coverage shall mean optional additional cover relating to claims other than medical, for loss of personal items as set out in the schedule of benefits.

"Physician" as used in this Policy 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, however, such definition will exclude chiropractors and physiotherapists.

"Policy Year" means the 12 month period commencing on the Policy Effective Date, save that the period of coverage provided by the Policy shall run from the Effective Date until the Expiration Date.

"Pre-Existing Condition" for the purposes of this Policy shall mean:

- (a) a condition the symptoms of which would have caused a reasonable person to seek Diagnosis, medical advice, care or Treatment during the twelve (12) months prior to the Effective Date; or
- (b) a condition in respect of which Diagnosis, medical advice, care or Treatment was given or effected by a Physician to or for the Insured Person during the twelve (12) months prior to the Effective Date.

"Principal Sum" shall mean the amount set down in the Schedule of Benefits.

"Reasonable and Customary" shall mean the maximum amount that the Company determines is Reasonable and Customary for Covered Expenses the Insured Person incurs, up to but not to exceed charges actually billed to the Insured Person. The Company's determination in this regard shall take account of:

- (a) amounts charged by other service providers for the same or similar service in the locality were received, considering the nature and severity of the bodily Injury or Illness in connection with which such services and supplies are received;



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- (b) any usual medical circumstances requiring additional time, skill or experience; and
- (c) other factors the Company determines are relevant, including but not limited to, a resource based relative value scale.

"Relative" shall mean spouse, parent, sibling, son, daughter, grandparent, grandchild, step-parent, step-child, step-sibling, in-laws (parent, son, daughter, brother and sister), aunt, uncle, niece, nephew, legal guardian, ward, or cousin of the Insured Person.

"Treatment" means a method, act, product or resource (including any natural, artificial or synthetic medicine or medical implement or equipment) utilised to provide care or recovery in respect of, or heal, in whole or in part a cause or symptom of an Injury or Illness (including the limitation, control or reversal of pathological or traumatic change in the function or structure of any part of the body); advice from a Physician in respect of such method, act, product or resource is also Treatment; for the avoidance of doubt, the scope of Treatment includes inpatient and outpatient physiotherapy.

"Working Day" shall mean any of Monday to Friday in Connecticut USA, except for any public holiday in that State or the USA as a whole



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## PART III

### SCHEDULE OF BENEFITS

All Coverage and Benefits are in U.S. Dollar Amounts	
Base Plan – Mandatory to all Eligible Participants of the Policyholder	
Benefits	Maximum Limits
Injury and Illness Medical Maximum:	
Class 1:	Up to \$500,000 Per Injury or Illness
Class II:	Up to \$50,000 Per Injury or Illness
Class III:	Up to \$5,000 Per Injury or Illness
Deductible per Injury or Illness:	\$50
Coinsurance:	100% to Plan Maximum
Benefit Period Per Injury or Illness:	52 Weeks
Emergency Dental – Relief of Pain:	Up to \$500 per Period of Coverage
Emergency Dental – As the result of an Accident:	Up to Policy Maximum,
Chiropractic Care & Therapeutic Services	Maximum of \$50 per visit Maximum of 10 visits per Period of Coverage \$500 overall maximum per Period of Coverage
Accidental Death & Dismemberment:	
Principal Sum Per Insured Person:	\$6,000 Principal Sum
Aggregate Limit Per Occurrence – All Insured Persons:	\$1,000,000 Aggregate Limit
Emergency Medical Evacuation/Repatriation:	Up to \$100,000 per Period of Coverage
Return of Mortal Remains or Cremation:	Up to \$50,000 per Period of Coverage
Emergency Family Reunion:	Up to \$1,000 per Period of Coverage
Return Air Fare Benefit:	Up to \$1,000 per Period of Coverage
Optional Plan Upgrades (in addition to Basic Coverage): Must be chosen at time of enrollment into the Basic Program	
Benefits	Maximum Limits
Option #1: Recurrence of a Pre-Existing Condition:	Up to \$2,500 per Period of Coverage
Option #2: Personal Effects Loss:	Up to \$2,000 per Period of Coverage
Personal Effects Deductible:	\$100 per incident
Per Item Limit:	
Electronic Devices:	\$1,000
Computers:	\$ 500
All Other Covered Items:	\$ 100



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## PART IV

### SCOPE OF COVERAGE

Benefits are payable under this Policy for Losses and Covered Expenses incurred by an Insured Person for the items stated in Schedule of Benefits, subject to the following limitations and conditions:

The insurance package will commence on the Insured's outbound flight from the Insured's home country to the United States (no earlier than May 1). Coverage ends on the earlier of 153 days from the Insured's effective date, October 31st of the policy year or the date the Insured cease to be a participant in the Sponsored Program. Failure to show up at the Sponsoring Program will mean the insurance will be terminated back to the Effective Date.

- a) Expiration of the term of coverage, which is for a maximum of 153 days or until October 31, whichever comes first. Coverage remains in effect during any independent travel.
- b) The Insured's termination as a program participant as a result of the Insured's resignation or dismissal from the program.
- c) Disembarkment from the Insured's Sponsoring Program's return flight home, or departure from the United States if the Insured have provided the Insured's own transportation.

The Insured will not be covered by the Insured's insurance during any period in which the Insured accept employment, paid or otherwise, from any source other than the camp/resort with which the Insured have been placed by Camp America or Resort America. The plan does not cover travel outside the U.S. and Canada. The only exception is travel to Mexico, where coverage is limited to a trip of no more than 48 hours.



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## PART V

### BENEFITS

#### Medical Expense (Injury and Illness)

This Plan shall pay Reasonable and Customary charges for Covered Expenses, excess of the Deductible and Coinsurance up to the Maximum as shown in the Schedule of Benefits, incurred by the Insured person within the Benefit Period due to a covered Injury or Illness which occurred during the Period of Coverage outside the Insured Person's Home Country. Eligible expenses shall be those listed below and which are not excluded in the Exclusions and Limitations:

- a) Reasonable and customary charges made by a Physician for diagnosis, treatment and surgery. In addition, the Insurer shall pay for examination and treatment methods and medicine which have also proved to be successful or are applied in practice because no classical medical examination or treatment method or medicine is available. The Insurer can reduce the benefit amount paid under the Policy to the amount which would have incurred if existing methods or medicine were applied;
- b) Medical treatment and preparations as prescribed by a licensed Physician for the Insured;
- c) In-patient care in generally recognized Hospitals;
- d) Transportation, as may be deemed medically necessary, to the nearest Hospital in the agreed upon geographical area for the purpose of inpatient care and return transportation to the Insured's accommodation;
- e) Hearing and speaking devices, walking aids, supporting apparatuses, orthopaedic supports, orthopaedic shoes, bandages, hernia supports, elastic stockings, artificial limbs and wheelchairs. The Insurer shall reimburse the cost or rental of the simplest version, up to the purchase price of these aids which are medically necessary for the medical treatment of acute illness or injury.
- f) Hospital charges: standard daily semi-private room and board rate for inpatient accommodation and subsistence including standard nursing care, Intensive Care, Coronary Care. Outpatient charges shall be covered the same as any inpatient charges.
- g) Surgical charges on an inpatient or outpatient basis, including operating room charges and charges for the cost and administration of anaesthetics;
- h) Medication prescribed by a Physician;
- i) X-rays, laboratory and diagnostic tests: fees for technical and diagnostic services;
- j) Medical preparations and medical devices: restricted to a period of 60 days;
- k) Psychiatric evaluation to determine an illness, but not psychotherapy;
- l) In-patient and outpatient physiotherapy.
- m) Out-patient Diagnostic X-ray and Lab Services up to a maximum per Period of Coverage of \$500. Outpatient Diagnostic Cat Scans and MRI up to a maximum per Period of Coverage of \$1,000;
- n) Chiropractic services and physical therapy up to a maximum of \$50 per visit, with a maximum 10 visits per injury or illness. The overall maximum coverage per injury or illness for chiropractic care and physical Therapy is \$500, which includes X-ray and evaluation charges.

#### Emergency Dental - As the result of an Accident

Benefits are paid for Reasonable and Customary expenses in excess of the Deductible and Coinsurance up to the maximum as stated in the Schedule of Benefits for the emergency repair or replacement to sound, natural teeth damaged as the result of a Covered Accident.



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## Emergency Dental - Relief of Pain

Benefits are paid for Reasonable and Customary expenses in excess of the Deductible and Coinsurance up to the maximum as stated in the Schedule of Benefits for treatment to alleviate pain resulting from infection of gums or sound natural teeth. Covered Expenses shall be limited to the cost of initial emergency examination and initial treatment

## Accidental Death & Dismemberment

Benefits shall be paid to the Insured Person if Insured Person sustains an accidental Injury. The Injury must occur during the Period of Coverage and death or dismemberment as a result of that accident must occur within 365 days from the date of Accident. Benefits payable for any such loss shall be in accordance with the following table: If the Insured Person incurs more than one Loss stated in the following Table as the result of one Accident, only the largest amount, shall be payable.

Description of Loss	Percent of Principal Sum
Life	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
Either Hand or Foot and Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Hand or One Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Hearing in One Ear	25%
Thumb and Index Finger of Same Hand	25%

Maximum aggregate benefit per occurrence is \$1,000,000.

## Emergency Medical Evacuation/Repatriation

The Company shall pay benefits for Covered Expenses incurred up to the maximum stated in the Schedule of Benefits, if any Injury or covered Illness commencing during the Period of Coverage results in the Medically Necessary Emergency Medical Evacuation or Repatriation of the Insured Person. The decision for an Emergency Medical Evacuation or Repatriation must be arranged by the appointed 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 (due to inadequate medical facilities) to the nearest adequate medical facility where medical treatment can be obtained; or
- b) after being treated at a local medical facility, 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. Covered Expenses include transportation, medical services and medical supplies necessarily incurred in connection with an Emergency Medical Evacuation or Repatriation of the Insured Person.

In the event the Insured Person refuses to be Emergency Medically Evacuated or Repatriated, the Company shall not be liable for any medical expenses incurred after the date the Emergency Medical Evacuation or Repatriation is recommended.



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## Return of Mortal Remains or Cremation

The Company will pay the reasonable Covered Expenses incurred up to the maximum as stated in the Schedule of Benefits, to return the Insured Person's remains to his/her then current Home Country, if he or she dies. Covered Expenses include, but are not limited to, expenses for embalming, cremation, a minimally necessary container appropriate for transportation, shipping costs and the necessary government authorizations. All Covered Expenses in connection with a Return of Mortal Remains must be pre-approved and arranged by the appointed Assistance Company.

## Emergency Family Reunion

When the appointed Assistance Company and the Insured Person's attending Physician determine that it is necessary and prudent for the Insured Person to have an Emergency Medical Evacuation or Repatriation, the Company will pay to bring an individual of the Insured Person's choice, from their Home Country, to be at the Insured Person's side while the Insured Person is hospitalized and then accompany the Insured person during their return to their Home Country. Benefits will be paid up to the maximum as stated in the Schedule of Benefits for a round-trip economy airfare ticket as well as \$100 a day for reasonable travel and accommodation expenses not to exceed 10 days in total.

## Return Air Fare Expenses

The Company will pay for a one way economy class ticket, up to the maximum as stated in the Schedule of Benefits, to return the Insured Person back to their Home Country from the United States in the event that the Insured Person's parent, grandparent, sibling, or legal guardian incurs death or serious illness or injury provided:

- a) The illness or injury is deemed to be life threatening by the attending physician; and
- b) The illness or injury was not life threatening prior to the Insured Person's departure; and
- c) The Sponsoring Program has been advised and the appointed Assistance Company has arranged the transportation

Or

## Recurrence of a Pre-Existing Condition

In the event the Insured Person has a recurrence of a Pre-Existing Condition while covered under this plan, this Company will pay up to \$2,500 for Covered Expenses incurred as a result of a Pre-Existing Condition. For the avoidance of doubt, this benefit does not include coverage for known, scheduled or expected medical care, drugs or treatment that must occur during the Insured Person's Period of Coverage.

## Personal Effects Coverage

The Company will pay the Insured Person up to the maximum as stated in the Schedule of Benefits subject to a deductible for the loss or theft of the Insured Person's personal items.

The Company will not reimburse the Insured Person for the loss or theft of:

- money, notes, securities, tickets and documents (driver's licenses, passports, passes, etc.)
- jewelry, watches, articles consisting in whole or in part of silver, gold or platinum and furs
- animals, automobiles, automobile parts and equipment, motorcycles, skis, bicycles, boats, motors or other conveyances
- any kind of glasses (including sunglasses) and contact lenses



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## PART VI

### EXCLUSIONS

For benefits listed in the Schedule of Benefits, except Accidental Death & Dismemberment, this insurance does not cover:

- Any Pre-existing Condition as defined hereunder except as covered under the Recurrence of a Pre-Existing Condition Benefit. This exclusion does not apply to Emergency Evacuation/Repatriation or Return of Mortal Remains.
- Charges for treatment which exceed Reasonable and Customary charges
- Charges incurred for Surgery or treatments which is experimental, for research purposes, or is similarly for the purposes of general investigation, and not prescribed or undertaken with respect to an Illness or Injury sustained by the Insured Person in particular
- Services, supplies or treatment, including any period of Hospital confinement, which were not recommended, approved and certified as Medically Necessary and reasonable by a Physician
- Suicide or any attempt thereof, while sane or self destruction or any attempt thereof, while sane
- Any consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to, or arising in connection with: a) war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war or b) mutiny, riot, strike, military or popular uprising insurrection, rebellion, revolution, military or usurped power
- Routine physicals, immunizations, or other examinations where there are no objective indications or impairment in normal health, and laboratory diagnostic or x-ray examinations, except in the course of a Disablement established by a prior call or attendance of a Physician
- Treatment of the Temporomandibular joint
- Vocational, speech, recreational or music therapy
- Services or supplies performed or provided by a Relative of the Insured Person, or anyone who lives with the Insured Person
- The refusal of a Physician or Hospital to make all medical reports and records available to the Company will cause an otherwise valid claim to be denied
- Cosmetic or plastic Surgery, except as the result of a covered Accident; for the purposes of this Policy, treatment of a deviated nasal septum shall be considered a cosmetic condition
- Elective Surgery/Treatment which can be postponed until the Insured Person returns to his/her Home Country, where the objective of the trip is to seek medical advice, treatment or Surgery
- Eye refractions or eye examinations for the purpose of prescribing corrective lenses for eye glasses or for the fitting thereof, unless caused by Accidental bodily Injury incurred while insured hereunder
- Treatment in connection with alcoholism and drug addiction, or use of any drug or narcotic agent
- Injury sustained while under the influence of or Disablement due to wholly or partly to the effects of intoxicating liquor or drugs other than drugs taken in accordance with treatment prescribed and directed by a Physician for a condition which is covered hereunder
- Any Mental and Nervous disorders or rest cures, except as specified
- Treatment while confined primarily to receive custodial care, educational or rehabilitative care, or nursing services
- Congenital abnormalities and conditions arising out of or resulting therefrom
- Expenses as a result or in connection with intentionally self-inflicted Injury or Illness
- Expenses as a result or in connection with the commission of a felony offense
- Hang gliding, parachuting, bungee jumping, racing by horse, motor vehicle or motorcycle, parasailing
- Injuries for which benefits are payable under any no-fault automobile Insurance Policy
- Routine Dental Treatment
- For Pregnancy or Illness resulting from Pregnancy, childbirth or miscarriage



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- Drug, treatment or procedure that either promotes or prevents conception, or prevents childbirth, including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal thereof, or abortion
- Treatment for human organ tissue transplants and their related treatment
- Weak, strained or flat feet, corns, calluses, or toenails
- Diagnosis and treatment of acne
- Injury sustained while the Insured Person is riding as a pilot, student pilot, operator or crew member, in or on, boarding or alighting from, any type of aircraft.
- Any Injury or Illness (or any Injury or Illness arising in whole or in part therefrom) which the Insured Person intended to sustain (including by the means or agency of another person on a voluntary or involuntary basis);

In addition to the exclusions listed above, the following exclusions apply to Accidental Death and Dismemberment Insurance only:

- disease of any kind
- bacterial infections except pyogenic infection which shall occur through an accidental cut or wound
- neuroses, psychoneuroses, psychopathies, psychoses or mental or emotional diseases or disorders of any type

The following exclusions apply to Personal Effects Coverage only:

- breakage of articles of a brittle nature unless caused by thieves
- loss or damage caused by, or resulting from, declared or undeclared war
- loss due to wear, tear, gradual deterioration or negligence on the part of the Insured.



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## PART VII

### GENERAL PROVISIONS

**ENTIRE CONTRACT CHANGES:** The policy, including the endorsements and attached papers, if any, shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed herein or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date. All statements made by the Policyholder will, in the absence of fraud, be deemed representations and not warranties.

**NOTICE OF CLAIM:** Written notice of claim must be given to the company within 20 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Company or its authorized representatives with information sufficient to identify the claimant shall be deemed notice to the Company.

**CLAIM FORMS:** Upon receipt of a notice of claim, the Company 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 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

**PROOF OF LOSS:** Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will 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. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

**TIME OF PAYMENT OF CLAIM:** Benefits payable under this policy for any loss other than for loss which the policy provides any periodic payment will be paid immediately upon the Company's receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which this policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

**PAYMENT OF CLAIMS:** Upon receipt of due written proof of death, payment for loss of life of an Insured will be made in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such beneficiary designation is effective, payment will be made to the Insured's estate. If an Insured dies before all payments due have been made, the amount still payable will be paid, at the option of the Company, either to such beneficiary or to such estate.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured suffering the loss.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or



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her property, a payment not exceeding \$1,000 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

**PHYSICAL EXAMINATION AND AUTOPSY:** The Company at its own expense has the right and opportunity to examine the person of any individual whose loss is the basis of claim under this Policy when and as often as it may reasonably require during the pendency of the claim and to make an autopsy in case of death where it is not forbidden by law.

**LEGAL ACTIONS:** No action at law or in equity shall be brought to recover on this policy prior to the expiration to 60 days after written proofs of loss have been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

**RIGHT OF SUBROGATION:** To the extent the Company pays for a loss suffered by an Insured, the Company will take over the rights and remedies the Insured had relating to the loss. This is known as subrogation. The Insured must help the Company to preserve its rights against those responsible for the loss. This may involve signing any papers and taking any other steps the Company may reasonably require. If the Company takes over an Insured's rights, the Insured must sign an appropriate subrogation form supplied by the Company.

**RIGHT OF RECOVERY:** Payments made by the company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations who are obligated in respect of any covered Injury or Sickness and their liability may appear.

**MORE THAN ONE POLICY:** Insurance effective at any one time on the Insured person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

**INCONTESTABILITY.** The validity of this Policy will not be contested after it has been in force for two year(s) from the Policy Effective Date, except as to nonpayment of premiums.

**ASSIGNMENT.** This Policy is non-assignable. An Insured may not assign any of his or her rights, privileges or benefits under this Policy.

**MISSTATEMENT OF AGE.** If premiums for the Insured are based on age and the Insured has misstated his or her age, there will be a fair adjustment of premiums based on his or her true age. If the benefits for which the Insured is insured are based on age and the Insured has misstated his or her age, there will be an adjustment of said benefit based on his or her true age. The Company may require satisfactory proof of age before paying any claim.

**WORKERS' COMPENSATION.** This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.



# Camp America Master Policy

## Your right to complain - the Financial Ombudsman Service

If you (the Insured Person) have a complaint about anything relating to the sale of this policy, please contact Annette Gaul, Managing Director of CareMed, Oscar-Romero-Allee 15 53113 Bonn, Germany, telephone number: +49 228 55 54 90 0.

If you are not happy with CareMed's final response in relation to your complaint, or they are unable to resolve your complaint, you can contact the Financial Ombudsman Service at South Quay Plaza, 183 Marsh Wall, London, E14 9SR, Phone 0845 080 1800,  
Email: [\*\*complaint.info@financial-ombudsman.org.uk\*\*](mailto:complaint.info@financial-ombudsman.org.uk)

If you have any complaints about the operation of this policy (including in relation to any claim which may have been declined) please contact ACE at ACE European Group Limited, UK Head Office, ACE Building, 100 Leadenhall Street, London EC3A 3BP, telephone number 0207 173 7000:

If you are not happy with ACE's final response in relation to your complaint, or they are unable to resolve your complaint, you can contact the Financial Ombudsman Service at South Quay Plaza, 183 Marsh Wall, London, E14 9SR, Phone 0845 080 1800,  
Email: [\*\*complaint.info@financial-ombudsman.org.uk\*\*](mailto:complaint.info@financial-ombudsman.org.uk)

## Financial Services Compensation Scheme (FSCS)

ACE is covered by the FSCS. If it is unable to meet its financial obligations you may be entitled to compensation from the scheme at 7th Floor Lloyds Chambers, Portsoken Street, London E1 8BN

## Your right to cancel

For a period up to 14 days from the date on which the Insured Person in fact received his or her Policy documents, he or she shall be entitled to cancel this Policy and obtain a refund of premium. In order to do so, please contact Annette Gaul, Managing Director of CareMed, telephone number: +49 228 55 54 90 0. If cover has not commenced, all premium shall, within 30 days from the date you request cancellation, be refunded. Once a request for cancellation has been made, no claims will be paid for under this policy.

The Policyholder and ACE European Group Limited (ACE) agree that:

The Policyholder will pay the Premium as agreed.

ACE will subject to the terms, Conditions, Provisions and Exclusions of this Policy, provide the Insurance in the manner and to the extent set out in this Policy. All information supplied to ACE by the Policyholder shall be incorporated into and be the basis of this Policy.

This Policy, the Schedule(s) and endorsements, if any, shall be read together as one contract and any word or expression to which specific meaning has been attached shall unless the context otherwise requires bear such meaning wherever it may appear.

A handwritten signature in black ink, appearing to read 'Andrew Kendrick'.

Andrew Kendrick  
Chairman and CEO  
ACE European Group Limited