

INBOUND[®]

CHOICE



INJURY & SICKNESS MEDICAL INSURANCE FOR VISITORS

Continuous & Renewable Protection. Coverage For Families & Individuals.



SEVEN CORNERS

ELIGIBILITY

WHO CAN BUY INBOUND® CHOICE?

You are eligible for coverage if you are a non-United States citizen, who is at least 14 days old or younger than 70 years of age, and traveling to the U.S. for business, pleasure, to study, or to visit. Your coverage must become effective within 24 months of your arrival in the United States.

It is your responsibility to maintain all records regarding travel history and age and provide necessary documents to Seven Corners to verify eligibility if required.

LENGTH OF COVERAGE

Your coverage length may vary from 5 days to a maximum of 364 days in a policy period. Your total period of coverage cannot exceed 728 days (two 364-day policy periods). You have the option to renew coverage in any increment of 5 days or more (there is a \$5 fee each time you renew).

coverage start date - Coverage will not begin until you leave your home country and we receive your application and premium. This is your effective date.

coverage expiration date - Your coverage ends at 12:01 A.M. North American Eastern Time on the earlier of the following: the expiration date on your ID card; the 31st day of your trip to your home country; after completion of 364 days of coverage, unless the company agrees to extend coverage upon such expiration (coverage is available up to 2 years); the day you become a U.S. citizen; the date you enter active military service.

Home Country means the country where your passport was issued.

WHY CHOOSE INBOUND® CHOICE?

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You can feel confident with Inbound® Choice's strong financial backing through Certain Underwriters at Lloyd's, London, an established organization with an AM Best rating of A (*Excellent*). Your coverage will be there when you need it.

As your plan administrator, Seven Corners* will handle all of your insurance needs from start to finish. We will process your purchase, provide all documents, & handle any claims. In addition, our own 24/7 in-house travel assistance team, Seven Corners Assist, will handle your emergency or travel needs. We have 20 years of experience with travel insurance, and we are here to help.

*In California, operating under the name Seven Corners Insurance Services.

IMPORTANT BENEFIT HIGHLIGHTS

MEDICAL BENEFITS - If your covered injury or sickness requires medical treatment, we will pay the coverage amounts listed in the schedule of benefits, minus your chosen per person deductible. Treatment must be received within 364 days of the injury or sickness.

HOME COUNTRY COVERAGE - We will pay up to \$50,000 for an illness or injury which occurs while you are on an incidental trip to your home country (30 days per 364 days of purchased coverage or pro rata thereof, approximately 2½ days per month).

INTERNATIONAL TRAVEL COVERAGE - If you buy at least 30 days of coverage, you may travel to countries other than the United States for up to 30 days. This benefit does not include travel back to your home country, and it does not extend after your current expiration date.

DESCRIPTION OF COVERAGE

EMERGENCY MEDICAL EVACUATION* - If medically necessary:

1. We will transport you to adequate medical facilities.
2. We will transport you home after receiving medical treatment related to a medical evacuation.

RETURN OF MORTAL REMAINS* - We will return your remains to your home country if you should die while traveling.

*Arrangements for evacuation & return of remains must be made by Seven Corners Assist.

COMMON CARRIER ACCIDENTAL DEATH & DISMEMBERMENT

This benefit pays up to \$25,000 for accidents occurring while you are riding as a passenger in or on any land, water or air conveyance transporting passengers for hire. Your loss must occur within 365 days after the accident date. A description of the covered losses is shown below:

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

CLAIMS

Filing a claim is easy! Simply send the itemized bill to Seven Corners within 90 days, along with a completed claim form. Payments can be converted to a currency of your choosing. You're only responsible for your deductible & coinsurance & any non-eligible expenses.

PRE-EXISTING CONDITIONS

Pre-existing conditions are defined in detail in the policy. A brief summary is shown here.

Pre-existing conditions include any medical condition, sickness, injury, illness, disease, mental illness or mental nervous disorder that existed with reasonable medical certainty during the 180 days before your coverage on Inbound Choice began, whether or not it was previously manifested, symptomatic, known, diagnosed, treated or disclosed. This includes but is not limited to any medical condition, sickness, injury, illness, disease, mental illness or mental nervous disorder for which medical advice, diagnosis, care or treatment was recommended or received or for which a reasonably prudent person would have sought treatment during the 180 days before the effective date.

ACUTE ONSET

Non U.S. Citizens traveling in the United States

We pay up to the specified limit for an acute onset of a pre-existing condition *if the condition occurs in the United States during your coverage period, & if you receive treatment in the United States within 24 hours of the sudden & unexpected recurrence*. A pre-existing condition that is chronic, congenital or gradually worsens over time is not covered.

SCHEDULE OF BENEFITS & COVERED EXPENSES

	Age 14 Days To Age 69 - Plan A	Age 14 Days To Age 69 - Plan B	Age 14 Days To Age 69 - Plan C	Age 14 Days To Age 69 - Plan D
	\$50,000 max per injury/sickness	\$75,000 max per injury/sickness	\$100,000 max per injury/sickness	\$130,000 max per injury/sickness
INPATIENT				
Hospital Room & Board including Laboratory Tests, X-rays, Prescription Medical and other miscellaneous	Up to \$1,500/day, 30 day max	Up to \$2,000 per day, 30 day max	Up to \$2,500/day, 30 day max	Up to \$3,000/day, 30 day max
Hospital Intensive Care Unit	Additional \$500/day, 8 day max	Additional \$500/day, 8 day max	Additional \$500/day, 8 day max	Additional \$800/day, 8 day max
Surgical Treatment	Up to \$2,100	Up to \$4,800	Up to \$5,800	Up to \$7,200
Anesthetist	Up to \$500	Up to \$750	Up to \$1,000	Up to \$1,650
Assistant Surgeon	Up to \$500	Up to \$750	Up to \$1,000	Up to \$1,650
Physician's Non-Surgical Visits	Up to \$38/visit, 1/day, 30 visits	Up to \$56/visit, 1/day, 30 visits	Up to \$75/visit, 1/day, 30 visits	Up to \$100/visit, 1/day, 30 visits
Consultant Physician, when requested by attending Physician	Up to \$250	Up to \$325	Up to \$500	Up to \$575
Pre-Admission Tests w/in 7 days before Hospital admission	Up to \$650	Up to \$975	Up to \$1,300	Up to \$1,300
Private Duty Nurse	Up to \$650	Up to \$650	Up to \$650	Up to \$650
OUTPATIENT				
Surgical Treatment	Up to \$2,100	Up to \$4,800	Up to \$5,800	Up to \$7,200
Anesthetist	Up to \$500	Up to \$750	Up to \$1,000	Up to \$1,650
Assistant Surgeon	Up to \$500	Up to \$750	Up to \$1,000	Up to \$1,650
Physician's Non-Surgical /Urgent Care Visits	Up to \$38/visit, 1/day, 10 visits	Up to \$56/visit, 1/day, 10 visits	Up to \$75/visit, 1/day, 10 visits	Up to \$100/visit, 1/day, 10 visits
Diagnostic X-rays & Lab Services	Up to \$250; Additional \$325 - One CAT scan, PET scan or MRI	Up to \$375; Additional \$325 - One CAT scan, PET scan or MRI	Up to \$500; Additional \$975 - One CAT scan, PET scan or MRI	Up to \$575; Additional \$975 - One CAT scan, PET scan or MRI
Hospital Emergency Room	Up to \$200 max	Up to \$300 max	Up to \$400 max	Up to \$650 max
Prescription Drugs	Up to \$68	Up to \$101	Up to \$135	Up to \$200
Outpatient Surgical Facility	Up to \$600	Up to \$900	Up to \$1,200	Up to \$1,400
OTHER SERVICES				
Ambulance Services	Up to \$500	Up to \$500	Up to \$500	Up to \$500
Initial Orthopedic Prosthesis/Brace	Up to \$663	Up to \$994	Up to \$1,325	Up to \$1,600
Chemotherapy and/or Radiation Therapy	Up to \$663	Up to \$994	Up to \$1,325	Up to \$1,600
Dental Treatment for Injury to Sound, Natural Teeth	Up to \$650	Up to \$650	Up to \$650	Up to \$650
Mental & Nervous Disorder & Substance Abuse	Same as any Sickness	Same as any Sickness	Same as any Sickness	Same as any Sickness
Physiotherapy	Up to \$45/visit, 1/day, 12 visits	Up to \$45/visit, 1/day, 12 visits	Up to \$45/visit, 1/day, 12 visits	Up to \$45/visit, 1/day, 12 visits
Emergency Evacuation	\$50,000	\$50,000	\$50,000	\$50,000
Return of Remains	\$25,000	\$25,000	\$25,000	\$25,000
Common Carrier AD&D Principal Sum	\$25,000	\$25,000	\$25,000	\$25,000
Acute Onset of a Pre-existing Condition	\$50,000 per policy period for Medical Expense Benefits (subject to the sublimits for each benefit shown above) & \$25,000 per policy period for Emergency Medical Evacuation.	\$75,000 per policy period for Medical Expense Benefits (subject to the sublimits for each benefit shown above) & \$25,000 per policy period for Emergency Medical Evacuation.	\$100,000 per policy period for Medical Expense Benefits (subject to the sublimits for each benefit shown above) & \$25,000 per policy period for Emergency Medical Evacuation.	\$130,000 per policy period for Medical Expense Benefits (subject to the sublimits for each benefit shown above) & \$25,000 per policy period for Emergency Medical Evacuation.

EXCLUSIONS & LIMITATIONS

MEDICAL EXCLUSIONS

See Program Summary for a complete list of exclusions.

- Pre-existing Conditions as defined. If you are a non-U.S. citizen under age 70, this exclusion is waived for an Acute Onset of a Pre-existing Condition as shown in the schedule of benefits for your plan (A, B, C & D). Benefits will be paid for expenses incurred in the U.S., minus your deductible & subject to the scheduled limits. All other exclusions apply.
- Any loss occurring while traveling solely for medical treatment, while on a waiting list for treatment, or while traveling against the advice of a Physician; expenses which are not medically necessary;
- The maximum benefit is \$50,000 for any illness/injury occurring while on an incidental trip to your home country (home country coverage);
- Routine physicals, inoculations, exams with no objective indications of impairment of normal health; well-baby care; routine newborn baby care, well-baby nursery;
- Eye exams & treatment of visual defects; glasses; contact lenses.
- Hearing exams; hearing aids; treatment for hearing defects;
- Dental treatment unless due to injury to sound, natural teeth; false teeth, dentures; dental appliances;
- Weak, strained or flat feet, corns, calluses, or toenails;
- Cosmetic surgery, or treatment for congenital anomalies (*except as specifically provided*), except reconstructive surgery due to a covered injury or sickness; Correction of a deviated nasal septum is considered cosmetic surgery unless it results from a covered injury/sickness;
- Elective surgery and elective treatment;
- Treatment, drugs, diagnostic or surgical procedures for infertility, impotency, artificial insemination, sterilization or reversal thereof, unless infertility is a result of a covered injury/sickness;
- Birth control, including surgical procedures & devices;
- Injury while participating in professional, sponsored, &/or organized amateur or intercollegiate athletics;
- Injury while taking part in mountaineering, hang gliding, parachuting, bungee jumping, racing by horse or motor vehicle or motorcycle, snowmobiling, motorcycle/motor scooter riding (*as a passenger or driver*), scuba diving involving underwater breathing apparatus (*unless PADI or NAUI certified*), water skiing, wakeboard riding, jet skiing, windsurfing, snow skiing & snowboarding;
- Injury or sickness where benefits are payable under Worker's Compensation or an Occupational Disease Law or Act;
- Organ & tissue transplants & related services & supplies;
- Any consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to, or arising in connection with war, invasion, act of foreign enemy hostilities, warlike operations (*whether war be declared or not*), or civil war; terrorist activity; nuclear, chemical, or biological weapons of mass destruction; (*additional details in the policy*);
- Suicide or attempted suicide (*including drug overdose*), while sane or insane; intentionally self-inflicted Injury;
- Charges of an institution, health service, or infirmary which does not require payment in the absence of insurance;
- Treatment of nervous or mental disorders; treatment of alcohol, chemical, or drug addiction, dependency, use or abuse, including illness caused by such use; injuries related to alcohol, chemicals or drugs unless prescribed by a physician, except as stated in the schedule of benefits for mental & nervous disorders;
- Loss from riding in any aircraft, other than as a passenger in an aircraft licensed for the transportation of passengers;
- Treatment, services, supplies in a hospital owned/operated by: a) The Veteran's Administration; or b) A national government or its agencies. (*This exclusion does not apply to treatment you are required by law to pay*);
- Duplicate services of a certified nurse-midwife & physician;
- Expenses payable under any prior policy in force for the person making the claim; expense covered by any other valid & collectible medical, health or accident insurance;
- A hospital emergency room visit not of an emergency nature;
- Outpatient treatment for 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 & the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column;
- Injury due to you operating a motor vehicle while not properly licensed to do so;
- Voluntary or elective abortion;
- Expense incurred after this insurance terminates except as may be specifically provided;
- Sexually transmitted & venereal diseases & any consequences thereof;
- Treatment incurred by you if you were HIV Positive at the time of application for this insurance, whether or not you were asymptomatic or symptomatic or had knowledge of your HIV status on your effective date or any associated diagnostic tests or charges for HIV infection, seropositivity to the AIDS virus, AIDS related illness(es), ARC Syndrome, AIDS, & all diseases caused by &/or related to HIV;
- Treatment for HIV, the AIDS virus, AIDS related illness, ARC Syndrome, AIDS, & all diseases & illnesses caused by &/or related to HIV or arising as complications from these conditions including the cost of testing for these conditions &/or charges for drug treatment or surgeries;
- Treatment for tuberculosis, malaria, cholera, dengue fever & parasitic-

- sourced illnesses, including treatment required as a result of complications from those same diseases, whether or not previously manifested or symptomatic prior to your effective date;
- Expenses which are experimental/investigational or for research purposes; vocational, speech, recreational or music therapy; durable medical equipment;
- Chiropractic care or complementary medicine including acupuncture and massage;
- Services/supplies provided by your relative or anyone living with you;
- Treatment of the temporomandibular joint;
- Treatment required as a result of complications or consequences of a treatment or for a condition not covered under this policy;
- Expenses for home health care, custodial care &/or daily living;
- Expenses for environmental supplies, including handrails, ramps, special telephones, air conditioners, home delivered meals.

Please be aware that this is not a general health insurance policy, but an interim program intended for temporary use. We do not guarantee payment to a facility or individual for medical expenses until we determine it is an eligible expense.

PLAN COST

Rates Effective November 18, 2013

Premiums for Ages 69 and Younger

\$0 per injury/sickness deductible per person

Policy Maximum Options

Age	Plan A	Plan B	Plan C	Plan D
	\$50,000	\$75,000	\$100,000	\$130,000
	Daily	Daily	Daily	Daily
2 weeks to 18	\$1.08	\$1.36	\$1.62	\$2.21
19 to 29	\$1.14	\$1.43	\$1.71	\$2.33
30 to 39	\$1.38	\$1.62	\$1.90	\$2.47
40 to 49	\$1.38	\$1.62	\$1.90	\$2.47
50 to 59	\$1.90	\$2.23	\$2.57	\$3.37
60 to 69	\$2.19	\$2.57	\$2.95	\$3.80
Dependent Child*	\$1.05	\$1.33	\$1.57	\$2.09

\$50 per injury/sickness deductible per person

Policy Maximum Options

Age	Plan A	Plan B	Plan C	Plan D
	\$50,000	\$75,000	\$100,000	\$130,000
	Daily	Daily	Daily	Daily
2 weeks to 18	\$0.90	\$1.08	\$1.26	\$1.76
19 to 29	\$0.95	\$1.14	\$1.33	\$1.85
30 to 39	\$1.14	\$1.33	\$1.52	\$2.04
40 to 49	\$1.14	\$1.33	\$1.52	\$2.04
50 to 59	\$1.57	\$1.85	\$2.09	\$2.80
60 to 69	\$1.85	\$2.14	\$2.42	\$3.18
Dependent Child*	\$0.86	\$1.09	\$1.28	\$1.71

\$100 per injury/sickness deductible per person

Policy Maximum Options

Age	Plan A	Plan B	Plan C	Plan D
	\$50,000	\$75,000	\$100,000	\$130,000
	Daily	Daily	Daily	Daily
2 weeks to 18	\$0.82	\$1.00	\$1.18	\$1.62
19 to 29	\$0.86	\$1.05	\$1.24	\$1.71
30 to 39	\$1.05	\$1.24	\$1.43	\$1.90
40 to 49	\$1.05	\$1.24	\$1.43	\$1.90
50 to 59	\$1.43	\$1.76	\$2.04	\$2.71
60 to 69	\$1.71	\$2.04	\$2.38	\$3.09
Dependent Child*	\$0.81	\$1.00	\$1.14	\$1.57

Dependent Child (Ages 2 weeks to 18) rate is applicable when at least one parent will also be covered under Inbound Choice.

(PLEASE PRINT OR TYPE)

Official Use Only:

Cert#: _____ Processed: _____ Eff. Date: _____ Agent: **11620**

APPLICANT INFORMATION

Mr. Mrs. Miss Ms.

Last Name: _____

First Name: _____

u.s. correspondence address: (Address must be in the United States)

Name: _____

Address: _____

City / State / Zip: _____

Phone Number: (____) _____

Email: _____

AD&D Beneficiary: _____ Relationship: _____

passport & travel information:

Passport Number: _____

Country Issuing Passport: _____

When did or will you arrive in the United States?

(MM/DD/YYYY) ____/____/____

Date you would like coverage to begin:

(MM/DD/YYYY) ____/____/____

Note: This program is not available to United States citizens. Your coverage must begin within 24 months of your arrival in the United States. The minimum period of coverage is 5 days, maximum is 364 days. An automatic renewal notice will be sent to the email address listed above. Total program length available is 728 days (approximately 24 months). Coverage cannot begin until you depart from your home country and Seven Corners both receives and accepts your application and correct premium.

COVERAGE SPECIFICS

Have you purchased insurance through Seven Corners before?

No Yes If Yes, ID Number: _____

Selected Medical Policy Maximum:

Plan A: \$50,000 Plan B: \$75,000 Plan C: \$100,000 Plan D: \$130,000

Selected Per Injury/Sickness Deductible:

\$0 \$50 \$100

Complete and return the application with payment made payable to:

**World Commercial Trust
P.O. Box: 56575, Station A
Toronto, ON M5W 4L1**

(You may fax your application only if paying by credit card. Originals are not required if application is faxed to Seven Corners with credit card payment.)

Attention Applicants: Certain Underwriters at Lloyd's, London operates as an approved Surplus Lines market in the United States. The premiums listed under Plan Cost include a 2% trust fee.

State Restrictions: Inbound Choice is not available for purchase in Maryland or Washington state.

In Florida, Florida Resident – Agent No. A269211

CALCULATING YOUR PLAN COST

(Please complete entire section.)

Name of Person(s) to be Insured:	Date of Birth MM/DD/YY	Monthly Rate	Daily Rate
Applicant: _____	____/____/____		
Spouse: _____	____/____/____		
Child: _____	____/____/____		
Child: _____	____/____/____		
Child: _____	____/____/____		
Total:		\$	\$

Multiply Monthly Rate Total by number of months:	x	
		Monthly Total [A]: \$
Multiply Daily Rate Total by number of days:	x	
		Daily Total [B]: \$
Administrative Fee (\$5.00 - Required):	+	\$5.00
Total Payment Enclosed:		\$

METHOD OF PAYMENT

Check Money Order MasterCard Visa
 Discover American Express

Card Number: _____

Expiration Date: _____ Daytime Phone: (____) _____

Name on Card: _____

Billing Address: _____

Signature (Required) _____

Please make check or money order payable to "World Commercial Trust." Total payment for the full term of your coverage must be paid in U.S. dollars (checks must be issued from a U.S. bank) at the time you apply. Purchase by credit card is subject to validation & acceptance by the credit card company. I declare that I understand the terms and conditions of this product. I understand that pre-existing conditions, as defined, are excluded, unless otherwise specifically noted as covered in the policy. I understand this program is for persons traveling outside their home country.

I hereby subscribe to the World Commercial Trust and enroll in the group coverage for which I am eligible under the group contract issued by Certain Underwriters at Lloyd's of London and the group contract issued by Tramount Insurance Company Limited.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an Insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I declare that I have read & understand the terms & conditions of this product. Whenever coverage provided by this policy would be in violation of U.S. or appropriate state law, including U.S. economic or trade sanctions, such coverage will be null & void.

Patient Protection and Affordable Care Act: This insurance is not subject to, and does not provide certain insurance benefits required by the United States Patient Protection and Affordable Care Act ("PPACA"). The insurance benefits provided by this policy are stated in your policy documents and do not include additional benefits required by PPACA. The PPACA requires certain U.S. residents and citizens to obtain PPACA compliant insurance coverage. In certain circumstances penalties may be imposed on U.S. residents and citizens who do not maintain PPACA compliant insurance coverage. You should consult your attorney, insurance agent or tax professional to determine if the PPACA's requirements are applicable to you.

Signature of Insured or Proxy (Required) _____ Date _____

ADMINISTERED BY



SEVEN CORNERS

303 Congressional Boulevard
Carmel, IN 46032
800-335-0611 • 317-575-2652 • Fax: 317-575-2870
www.SevenCorners.com



INSURANCE CARRIER

Inbound® Choice is underwritten by Certain Underwriters at Lloyd's of London, rated "A" (Excellent) by A.M. Best and "A+" (Strong) by Standard & Poor's.

This brochure is intended as a brief summary of benefits and services. It is not your policy. If there is any difference between this brochure and your policy, the provisions of the policy will prevail. Benefits and premiums are subject to change.

FOR ADDITIONAL INFORMATION