Collegiate Care Description of Coverage

Underwritten by: GBG Insurance Limited

Policy Number: TCC-006, TCC-007, TCC-008 **Member ID #:** 980260470

Covered Person: TEST TEST **DOB:** 01/05/1987

Premium Paid: $2460.92

If you have questions about your coverage, please contact your agent:

Trawick International, Inc. 888-301-9289

PART A: ACCIDENT BENEFITS

ACCIDENTAL DEATHAND DISMEMBERMENT BENEFITS 24-Hour (Other than Air Flight)

Class 1 Principal Sum: **$15,000**

Time Period for Loss: **90 days**

Loss of:	**Benefit: (Percentage of Principal Sum)**
Loss of Life	100%
Loss of Both Hands or Feet, or Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand or Foot and Entire Sight of One Eye	100%
Loss of One Hand or Foot	85%
Loss of Sight of One Eye	85%

ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS

Benefits will be provided only for the Coverages listed below and will be paid only up to the amounts shown.

Plan Term Maximum for all Medical	Unlimited
Deductible Per Plan Participant Per Policy Term	Network Provider: $100, $500, or $1,500 Non-Network Provider: $250, $1,500, or $2,500

The Deductible will be waived when treatment is rendered at the Student Health Center.

Out-of-Pocket Maximum:	In-Network: $6350 Individual/ $8,000 Family (including deductible) Out-of-Network: Unlimited
Per Plan Term:	
Coinsurance:	In-Network: 80% of the Preferred Allowance Out-of-Network: 70% of Usual, Reasonable & Customary (URC) Charges
Co-Payment:	
Office Visit:	$25 per Occurrence, Not including Student Health Center.
Urgent Care Center:	$50 per Occurrence
Emergency Room Deductible:	$150 per Occurrence
Terms of Payment	Full Excess
Lifetime Maximum	Unlimited

Any Deductibles, Coinsurance, Co-payments, Benefit Periods, and Benefit Maximums apply on a per Plan Participant basis.

After the Deductible has been satisfied, benefits will be paid as listed for the Provider selected.

BENEFIT/COVERAGE	BENEFIT AMOUNT	
	In-Network Provider Benefit	**Out-of-Network Provider Benefit**
Hospital Room & Board Benefit	80% of the Preferred Allowance	70% of the Semi-Private Room Rate
Intensive Care/Cardiac Care Unit Benefit	80% of the Preferred Allowance	70% of URC
Hospital Miscellaneous Expense Benefit	80% of the Preferred Allowance	70% of URC
Extended Care/Inpatient Rehabilitation • Up to 45 days	80% of the Preferred Allowance	70% of URC
Private Duty Nursing Care	80% of the Preferred Allowance	70% of URC
Surgeon (In or Outpatient) Benefits	80% of the Preferred Allowance	70% of URC
Pre-Admission Testing Benefit	80% of the Preferred Allowance	70% of URC
Anesthesia Benefit	80% of the Preferred Allowance	70% of URC
Day Surgery Miscellaneous Benefit	80% of the Preferred Allowance	70% of URC
Diagnostic X-Ray and Lab Benefit	80% of the Preferred Allowance	70% of URC
Ambulance Benefit	80% of the Preferred Allowance	80% of URC
Physician Visit Benefit (Inpatient)	80% of the Preferred Allowance	70% of URC
Physician Visit Benefit (Outpatient)	80% of the Preferred Allowance	70% of URC
Consultant Physician Benefit	80% of the Preferred Allowance	70% of URC
Radiation/Chemotherapy Benefit	80% of the Preferred Allowance	70% of URC
Emergency Room Benefit • 50% Coinsurance for Non-emergency use	80% of the Preferred Allowance subject to a $150 Co-Payment, waived if admitted	70% of URC subject to a $150 deductible per visit, waived if admitted
Wellness Medical Benefit	100% of the Preferred Allowance, deductible does not apply 0-12 months: Exam, immunizations and routine eye and hearing exams Child/Adult: Annual Exam, immunizations, and routine eye and hearing exams	No Benefit

BENEFIT/COVERAGE	BENEFIT AMOUNT	
	In-Network Provider Benefit	**Out-of-Network Provider Benefit**
Maternity and Pre-Natal Care Expense Benefit • Conception must occur while covered under the Policy	80% of the Preferred Allowance	70% of URC
MENTAL & NERVOUS CONDITIONS EXPENSE BENEFIT		
• **In-Patient Expense**	80% of the Preferred Allowance	70% of URC
• **Out-Patient Expense**	80% of the Preferred Allowance, subject to a $25 Co-Payment	70% of URC, subject to a $25 deductible per visit
ALCOHOL & DRUG ABUSE EXPENSE BENEFIT		
• **In-Patient Expense**	80% of the Preferred	70% of URC
• **Out-Patient Expense**	80% of the Preferred Allowance, subject to a $25 Co-Payment	70% of URC, subject to a $25 deductible per visit
Elective/Therapeutic Termination of Pregnancy Benefit • Conception must occur while covered under the Policy	80% of the Preferred Allowance	70% of URC
Emergency Dental Expense Benefit • Up to $250 per tooth to a $1,000 Maximum Benefit	80% of the Preferred Allowance	70% of URC
Physiotherapy Expense Benefit - Inpatient	80% of the Preferred Allowance	70% of URC
Physiotherapy Expense Benefit - Outpatient	80% of the Preferred Allowance	70% of URC
Motor Vehicle Accident	80% of the Preferred Allowance	70% of URC
Diabetic Medical Supplies	80% of the Preferred Allowance	70% of URC
Urgent Care	80% of the Preferred Allowance, subject to a $50 Co-Payment	70% of URC, subject to a $50 deductible per visit
Voluntary HIV Screening	100% of the Preferred Allowance	70% of URC
Rehabilitative Services for the Treatment of Congenital or Genetic Birth Defects	80% of the Preferred Allowance	70% of URC

BENEFIT/COVERAGE	BENEFIT AMOUNT	
	In-Network Provider Benefit	**Out-of-Network Provider Benefit**
Durable Medical Equipment Expense Benefit	80% of the Preferred Allowance	70% of URC
Sports Activities • Injuries arising from intramural, intercollegiate, interscholastic, leisure, and club sports	80% of the Preferred Allowance	70% of URC
Allergy Testing and Treatment	80% of the Preferred Allowance, subject to a $25 Co-Payment	70% of URC, subject to a $25 deductible per visit
Transplant Services	80% of the Preferred Allowance	No coverage
Hospice Care	80% of the Preferred Allowance	70% of URC
Emergency Medical Evacuation Expense Benefit	100% of actual expense	No Benefit
Emergency Medical Repatriation Expense Benefit	100% of actual expense	No Benefit
Return of Mortal Remains	100% of actual expense	No Benefit
PEDIATRIC SERVICES		
Pediatric Dental	50% of the Preferred Allowance	50% of URC

Pediatric Vision Care Service	**Frequency of Service**	**In-Network Benefit**	**Out-of-Network Benefit**
Routine Vision Examination or Refraction only in lieu of a complete exam	Once per year	100% after a Copayment of $20	50% of the billed charge
Eyeglass Lenses	Once per year		
• Single Vision		100% after a Copayment of $40	50% of the billed charge
• Bifocal		100% after a Copayment of $40	50% of the billed charge
• Trifocal		100% after a Copayment of $40	50% of the billed charge
• Lenticular		100% after a Copayment of $40	50% of the billed charge
Lens Extras	Once per year		
• Polycarbonate Lenses		100%	100% of the billed charge
• Standard scratch-resistant coating		100%	100% of the billed charge
• Oversized Lenses		20%	100% of the billed charge

Eyeglass Frames	Once per year		
• Eyeglass frames with a retail cost up to $130		100%	50% of the billed charge
• Eyeglass frames with a retail cost of $130-$160		100% after a Copayment of $15	50% of the billed charge
• Eyeglass frames with a retail cost of $160-$200		100% after a Copayment of $30	50% of the billed charge
• Eyeglass frames with a retail cost of $200-$250		100% after a Copayment of $50	50% of the billed charge
• Eyeglass frames with a retail cost greater than $250		60%	50% of the billed charge
Contact Lenses fitting and evaluation	Limited to a 12-month supply		
• Covered Contact Lens Selection		100% after a Copayment of $40	50% of the billed charge
• Necessary Contact Lenses		100% after a Copayment of $40	50% of the billed charge
Low Vision Services **Note:** Benefits for these services will be paid as reimbursements. When obtaining these Vision services, the Plan Participants will be required to pay all billed charges at the time of service. The Plan Participant may then obtain reimbursement will be limited to the amount stated.			
• Low Vision Testing		100% of the billed charge	75% of the billed charge
• Low Vision Therapy		100% of the billed charge	75% of the billed charge

PRESCRIPTION DRUG EXPENSE BENEFIT	**BENEFIT AMOUNT** **Network Provider**	**Non-Network Provider**
Co-payment (per prescription) • Contraceptives are included	Tier 1: $10 Copayment Tier 2: $20 Copayment Tier 3: $40 Copayment (up to a 31-day supply per prescription)	No benefit if a non-network pharmacy is used.

NOTES:

- We do not pay benefits for the amount of Eligible Expenses paid by You as Your Coinsurance or Co-pay amount.
- **Eligible Expenses** will be paid under the Inpatient benefits for Surgery and under the Outpatient benefits for Surgery, but not both for the same or related procedure.
- **The "Pre-existing Condition Waiting Period"** is 6 months. If you receive treatment or service for a Pre-Existing Condition: a) No benefits will be paid for such condition until the day after a 6 consecutive month period has passed from your effective date; and b) The plan will pay only for Covered Expenses incurred after such 6 consecutive month period.

DEFINITIONS

The male pronoun includes the female whenever used.

For the purposes of the Plan the capitalized terms used herein are defined as follows:

Additional terms may be defined within the provision to which they apply.

Accident means an unforeseeable event which:

1) Causes Injury to one or more Plan Participants; and

2) Occurs while coverage is in effect for the Plan Participant.

AIDS means Acquired Immune Deficiency Syndrome, as that term is defined by the United States Centers for Disease Control**.**

Air Carrier means any air conveyance operating under a valid license for the transportation of passengers for hire.

Benefit Period means the period of time from the date of the Accident causing the Injury for which benefits are payable, as shown in the Schedule of Benefits, and the date after which no further benefits will be paid.

Caregiver means an individual employed for the purpose of providing assistance with activities of daily living to the Plan Participant or to the Plan Participant's Immediate Family Member who has a physical or mental impairment. The Caregiver must be employed by the Plan Participant or the Plan Participant's Immediate Family Member. A Caregiver is not a babysitter; childcare service, facility or provider; or persons employed by any service, provider or facility to supply assisted living or skilled nursing personnel.

Child means the Plan Participant's natural Child, adopted Child (or Child placed in the Plan Participant's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Plan Participant has legal guardianship (proof will be required). A Child must reside with the Plan Participant in a parent-Child relationship. NOTE: In the event the Plan Participant shares physical custody of the Child with another parent, the requirement that the Child reside with the Plan Participant will be waived.

Child Caregiver means an individual providing basic childcare service needs for the Plan Participant's minor children under the age of 18 while the Plan Participant is on the Trip without the minor children. The arrangement of being the Child Caregiver while the Plan Participant is on the Trip must be made 30 or more days prior to the Scheduled Departure Date.

Civil Union Partner means a party to a civil union who is entitled to the same legal obligations, responsibilities, protections and benefits that are afforded a spouse. Throughout the Plan, a party to a civil union shall be included in any definition or use of the terms such as spouse, Immediate Family, dependent, next of kin, and other terms descriptive of spousal relationships. This includes the terms 'marriage' or 'married' or variations thereon. The term spouse or dependent includes civil union couples whenever used.

Class means a group of people defined by a common characteristic, including but not limited to demographic group and geographic region**.**

Common Carrier means any motorized land, sea, and/or air conveyance operating under a valid license for the transportation of passenger for hire**.**

Coinsurance means the percentage of Eligible Expenses for which the Company is responsible for a specified covered service after the Deductible, if any, has been met.

Company means GBG Insurance Limited. Also hereinafter referred to as We, Us and Our.

Complications of Pregnancy means a condition which:

- When pregnancy is not terminated, requires medical treatment and whose diagnosis is distinct from pregnancy

but is adversely affected by or are caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; and (i) other similar medical and surgical conditions of comparable severity related to pregnancy.

- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible;

Complications of Pregnancy will not include:

- False Labor;
- Occasional spotting;
- Physician prescribed rest during the period of pregnancy;
- Morning Sickness; and
- Similar conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a complication of pregnancy if the cesarean section is *non*-elective. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the Child or mother.

Co-Payment means a specified charge that the Plan Participant is required to pay when a medical service is rendered.

Cosmetic Surgery means the surgical alteration of tissue primarily for the improvement of appearance rather than to improve or restore bodily functions**.**

Covered Accident means an Accident that occurs while coverage is in force for a Plan Participant and results in a Covered Loss for which benefits are payable.

Covered Loss or Covered Losses means an accidental death, dismemberment or other Injury covered under the Plan and indicated on the Schedule of Benefits.

Custodial Care means that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Plan Participant, whether or not totally disabled, in the activities of daily living.

Deductible means the dollar amount of Eligible Expenses which must be incurred and paid by the Plan Participant before benefits are payable under the Plan. It applies separately to each Plan Participant.

Dentist means a legally licensed Doctor of Dental Surgery; dental medicine or dental science. A dental hygienist who works within the scope of his/her license, under the supervision of a Dentist, is a covered practitioner.

Dependent means a Plan Participant's:

1) lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner.
2) unmarried Children under age 26.

The age limitations will not apply to a Plan Participant's unmarried Child who is dependent on the Plan Participant or other care providers for lifetime care and supervision, and incapable of self-sustaining employment by reason of mental or physical handicap that occurred before age 26. Proof of such

dependence and incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.

Dive/Diving means recreational snorkeling or scuba diving, dive training or diving as a scuba instructor, dive master, underwater photographer or while performing research under the auspices and following the diving safety guidelines of the American Academy of Underwater Scientists. A Dive begins upon entry into the water and ends upon exit from the water. A Dive must occur in an area in which snorkeling and/or scuba diving is not prohibited. In the case of scuba Diving, the Plan Participant must be equipped with Personal Diving Equipment. Diving must be done by a person (a) At least 10 years of age and qualified as a diver; the holder of a valid diver's certificate (recognized by international diving organizations); and according to the generally accepted standards of the diving community or (b) who is in the process of obtaining his/her qualification as a diver and is under the supervision of and diving with a qualified diving instructor affiliated with a certifying organization or agency.

Domestic Partner means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Plan Participant and shared financial assets/obligations with the Plan Participant. Both the Plan Participant and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Plan Participant nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

Economy Transportation means the lowest published available transportation rate for a ticket on a Common Carrier matching the original class of transportation that the Plan Participant purchased for the Plan Participant's Trip.

Eligible Expenses means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Plan Participant for the Medically Necessary treatment of an Injury. Eligible Expenses must be incurred while the Plan is in force.

Emergency means a Sickness or Injury for which the Plan Participant seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause:

- His life or health would be in serious jeopardy, or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn Child;
- His bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

Experimental/Investigational means that a drug, device or medical care or treatment will be considered experimental/investigational if:

- The drug or device cannot be lawfully marketed without approval of the Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review

Board or other body serving a similar function, or if federal or state law requires such review and approval;

- Reliable Evidence show that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or
- Reliable Evidence show that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device or medical care at the time the expense is incurred.

Management staff in Our Claims Department or a Claims Payor acting on Our behalf will make the determination if the drug, device or medical care is Experimental/Investigational based on the above criteria.

Extended Care Facility means an institution operating pursuant to applicable laws that is engaged in providing, for a fee, inpatient skilled nursing care and related services under the supervision of a Physician and Registered Nurses. It must have facilities for 10 or more inpatients and maintain medical records of all its patients.

He, His and Him includes "she", "her" and "hers."

Health Care Plan means any contract, Plan or other arrangement for benefits or services for medical or dental care or treatment under:

1) Group or blanket insurance, whether on an insured or self-funded basis;
2) Hospital or medical service organizations on a group basis;
3) Health Maintenance Organizations on a group basis.
4) Group labor management plans;
5) Employee benefit organization plan;
6) Professional association plans on a group basis; or
7) Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.

Home Country means the country where a Plan Participant has his or her true, fixed and permanent home and principal establishment and holds a current and valid passport

Home Health Care means nursing care, treatment and Daily Living Services provided in the Plan Participant's home as part of an overall extended treatment plan. To qualify for Home Health Care Benefits:

1) the Home Health Care plan must be established and approved by the attending Physician, including certification that confinement in a Hospital or Extended Care Facility would be required if it were not for Home Health Care; and Necessary care and treatment are not available from a Plan Participant's Immediate Family Member or other persons residing with the Plan Participant without causing undue hardship;
2) nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified Home Health Care agency and nursing service; and

3) Daily Living Services must be provided by the attending Physician or by the provider of the nursing care service.

"Daily Living Services" are cooking, feeding, bathing, dressing and personal hygiene services that are necessary to a person's care and health.

Home Health Care consists of, but shall not be limited to, the following:

- Part time and intermittent skilled nursing services: services given to the Plan Participant at least once every 60 days or as frequently as a few hours per day, several days per week.
- Therapeutic services: physical therapy occupational therapy; speech and hearing therapy; and
- Medical social services, medical supplies, drugs and medicines, related pharmaceutical services and laboratory services to the extent such charges or costs would have been covered under the Evidence of Coverage if the Plan Participant had remained in the Hospital.

Host Country means any country other than the country where a Plan Participant has his or her true, fixed and permanent home and principal establishment and/or holds a current and valid passport

Hospital means an institution licensed, accredited or certified by the State that:

1) Operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons;
2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call;
4) Has a staff of one or more licensed Physicians available at all times;
5) Provides organized facilities for diagnosis, treatment and surgery, either
   a) on its premises; or
   b) in facilities available to it, on a pre-arranged basis;
6) Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
7) Is not a place for drug addicts, alcoholics or the aged.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

1) the Joint Commission of Accreditation of Hospitals; or
2) the American Osteopathic Association; or
3) the Commission on the Accreditation of Rehabilitative Facilities.

In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is an Eligible Expense under the Plan.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

Immediate Family means a Plan Participant's spouse, domestic partner, civil union partner, parent (includes Step-parent), Child(ren) (includes legally adopted or step Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws). A Member of the Immediate Family includes an individual who normally lives in the Plan Participant's household.

Injury means bodily harm which results independently of disease or bodily infirmity, from an Accident after the effective date of a Plan Participant's coverage under the Plan, while the Plan is in force as to the person whose Injury is the basis of the claim. All injuries to the same Plan Participant sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Incidental Trip means a trip to the Plan Participant's Home Country for up to30 days per 12 months of coverage.

Inpatient means a Plan Participant who is confined in an institution and is charged for room and board.

Insurance means the coverage that is provided under the Plan.

Intensive Care Unit means 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.

Intoxicated means a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Plan Participant is located at the time of an incident.

Maximum Benefit means the largest total amount of Eligible Expenses that the Company will pay for the Plan Participant as shown in the Plan Participant's Schedule of Benefits.

Medically Necessary means a treatment, drug, device, service, procedure or supply that is:

1) Required, necessary and appropriate for the diagnosis or treatment of a Sickness or Injury;
2) Prescribed or ordered by a Physician or furnished by a Hospital;
3) Performed in the least costly setting required by the condition;
4) Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

The purchasing or renting air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them, and general exercise equipment are not considered Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may consider the cost of the alternative to be the Eligible Expense.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental/Investigational or for research purposes;
- Is provided for education purposes or the convenience of the Plan Participant, the Plan Participant's family, Physician, Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;

- Could have been omitted without adversely affecting the person's condition or the quality of medical care;
- Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
- Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- It can be safely provided to the patient on a less cost-effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.

Mental or Nervous Disorder means any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the medical care or treatment is rendered to a Plan Participant.

Mountaineering means the sport, hobby, or profession of walking, hiking, and climbing up mountains either: 1) utilizing harnesses, ropes, crampons, or ice axes; or 2) ascending 4,500 meters or above.

Natural Teeth means the major portion of the individual tooth which is present, regardless of filings and caps; and is not carious, abscessed, or defective.

Network Provider means a Physician, Hospital and other healthcare providers who have contracted to provide specific medical care at negotiated prices.

Non-Network Provider means a Physician, Hospital and other healthcare providers who have not agreed to any pre-arranged fee schedules. A Plan Participant may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Plan Participant's responsibility.

Occurrence means all losses or damages that are attributable directly or indirectly to one cause or one series of similar causes. All such losses will be added together, and the total amount of such losses will be treated as one Occurrence without regard to the period of time or the area over which such losses occur.

Outpatient means a Plan Participant who receives care in a Hospital or another institution, including; ambulatory surgical center; convalescent/skilled nursing facility; or Physician's office, for a Sickness or Injury, but who is not confined and is not charged for room and board.

Outpatient Surgical Facility means a surgical or medical center which has (1) permanent facilities for surgery; (2) organized medical staff of Physicians and registered graduate Registered Nurses; (3) is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under law.

Out-of-Pocket Maximum means the maximum dollar amount the Plan Participant is responsible to pay during a Plan Term. After the Plan Participant has reached the Out-of-Pocket Maximum, the Plan pays 100% of Eligible Expenses for the remainder of the Plan Term. The Out-of-Pocket Maximum is met by accumulated Deductible, Coinsurance. Penalties and amounts above the Usual, Reasonable and Customary Expenses do not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is shown on the Schedule of Benefits.

Parachuting means an activity involving the breaking of a free fall from an airplane using a parachute

Physician means a person who is a qualified practitioner of medicine. As such, He or She must be acting within the scope of his/her license under the laws in the state in which He or She practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Plan Participant, a Plan Participant's Spouse, son, daughter, father, mother, brother or sister or other relative.

Physical Therapy means any form of the following administered by a Physician: (1) physical or mechanical therapy; (2) diathermy, (3) ultra-sonic therapy; (4) heat treatment in any form; or (5) manipulation or massage.

Plan Participant means a Person and Dependent eligible for coverage as identified in the Enrollment/Application as a Non-United States Citizen traveling outside their Home Country and as his or her true, fixed and permanent home and principal establishment outside of the United States and holds a current and valid passport for whom proper premium payment has been made when due, and who is therefore a Plan Participant under the Plan.

Plan means this document, the Application of the Plan Participant and any end endorsements, riders or amendments that will attach during the Period of Coverage.

Plan Period means the period of time following the Plan's Effective Date, as shown on the Schedule of Benefits.

Preferred Allowance means the amount a Network Provider will accept as payment in full for Eligible Expenses.

Pre-Existing Condition means an Injury, Sickness, disease, or other condition during the 365 day period immediately prior to the date the Plan Participant's coverage is effective 1) received or received a recommendation for a test, examination, or medical treatment for a condition which first manifested itself, worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment; or 2) took or received a prescription for drugs or medicine. Item (2) of this definition does not apply to a condition which is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the 365 day period before coverage is effective under the Plan Participant's Plan**.**

Pregnancy means the physical condition of being pregnant, including Complication of Pregnancy.

Prescription Drugs means drugs which may only be dispensed by written prescription under Federal law and approved for general use by the Food and Drug Administration.

Registered Nurse means a licensed registered professional Registered Nurse (R.N.).

Rehabilitation Facility means a non-residential facility that provides therapy and training rehabilitation services at a single location in a coordinated fashion, by or under the supervision of a physician pursuant to the law of the jurisdiction in which treatment is provided. The center may offer occupational therapy, physical therapy, vocational training, and special training such as speech therapy. The facility may be either of the following:

1) A Hospital or a special unit of a Hospital designated as a Rehabilitation Facility; or

2) A free-standing facility.

Scheduled Departure Date means the date on which the Plan Participant is originally scheduled to leave on the Plan Participant's Trip.

Scheduled Return Date means the date on which the Plan Participant is originally scheduled to return to the point of origin or the original final destination of the Plan Participant's Trip.

Service Provider means a Hospital, 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, Registered Nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility that the Company approves.

Sickness means Sickness or disease contracted and causing loss commencing while the Plan is in force as to the Plan Participant whose Sickness is the basis of claim. Any complication or any condition arising out

of a Sickness for which the Plan Participant is being treated or has received Treatment will be considered as part of the original Sickness.

Skilled Nursing Facility means a facility that provides skilled nursing 24 hours a day, seven days a week, under the supervision of a Registered Nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A Skilled Nursing Facility provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge.

Spouse means lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Partner.

Substance Abuse means alcohol, drug or chemical abuse, overuse or dependency.

Surgery or Surgical Procedure means an invasive diagnostic procedure; or the treatment of Sickness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.

Third Party means a person or entity other than the Plan Participant, or the Company.

Transportation Expense means the cost of Medically Necessary conveyance, personnel, and services or supplies.

Trip means a scheduled trip for which coverage for Travel Arrangements is requested and the premium is paid prior to the Plan Participant's actual or Scheduled Departure Date of the Plan Participant's Trip.

Usual, Reasonable and Customary means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred. The most common charge means the lesser of:

- The actual amount charged by the provider;
- The negotiated rate; or
- The charge which would have been made by the provider (Physician, Hospital, etc.) for a comparable service or supply made by other providers in the same Geographic Area, as reasonable determined by Us for the same service or supply.

"Geographic Area" means the three-digit zip code in which the service, treatment, procedure, drugs or supplies are provided; a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Usual, Reasonable and Customary Charges, Fees or Expenses as used in the Plan to describe expense will be considered to mean the percentile of the payment system in effect at Plan issue as shown on the Schedule of Benefits.

Utilization of Nuclear, Chemical or Biological weapons of mass destruction shall mean the use of:

- any explosive nuclear weapon or device; or
- the emission, discharge, dispersal, release or escape of:
- fissile material emitting a level of radioactivity, or
- any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins), or
- any solid, liquid or gaseous chemical compound which, when suitably distributed;
- which is capable of causing incapacitating disablement or death amongst people or animals.

We, Our, Us means GBG Insurance Limited.

You, Your, Yours, He or She means the Plan Participant who meets the eligibility requirements of the Plan and whose insurance under the Plan is in force.

ELIGIBILITY FOR INSURANCE

We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

The Plan Participant must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and television (TV) courses do not fulfill the eligibility requirements that the Plan Participant actively attend classes. The Plan Participant must attend a minimum of 6 hours to be eligible. We maintain the right to investigate student status and attendance records to verify that the Plan eligibility requirements have been met. If and whenever we discover that the Plan eligibility requirements have not been met, our only obligation is refund of premium.

A Plan Participant Person's Dependent(s), as applicable, are eligible on the latest of the date:

1) the Plan Participant is eligible, if the Plan Participant has Dependents on that date; or

2) the date the person becomes a Dependent; or

If the Plan Participant is in a Class of Eligible Persons and is also eligible as a Dependent, He or She may be Covered only once under the Plan. In no event will a Dependent be eligible if the Plan Participant is not eligible.

This insurance is not subject to and will not be administered as a PPACA (Patient Protection and Affordable Care Act) insurance plan. PPACA requires certain U.S. residents and citizens obtain PPACA compliant insurance coverage. This plan is not designed to cover U.S. residents and citizens. This Plan is not subject to guaranteed issuance or renewal.

EFFECTIVE DATES OF INSURANCE:

Plan Effective Date. The Plan begins on the Plan Effective Date shown in the Schedule of Benefits at 12:01 A.M. and will continue in force until either a) the Plan Expiration Date stated in the Schedule; or b) the Plan is cancelled pursuant to the terms of the Plan.

Plan Participant's Effective Date for all other Coverages:re

A Person will become a Plan Participant under the Plan, provided proper premium payment is made, on the latest of:

1) The Effective Date of the Plan; or

2) The date the Company receives a completed application or enrollment form; or

3) The day He becomes eligible, subject to any required waiting period, according to the referenced date requested and shown in the Application/Enrollment Form, Schedule of Benefits; or

4) The Date the Company approves the Application.

Newborn Children Coverage: Coverage for a newborn Child will begin from the moment of birth. You must give Us notice within 31 days of the birth of the Child. If notice is not given within 31days, coverage for the newborn Child will terminate upon the expiration of the initial 31-day period.

Newborn Adopted Children Coverage**:** In the case of adoption of a newborn Child, coverage will be on the same basis as a newborn Child if a written agreement to adopt such Child has been entered into by You

prior to the birth of the Child, whether or not such agreement is enforceable. Newborn Child Exception: This section does not apply to a newborn Child at that Child's birth if the Child is born to You while You are a Plan Participant as a Dependent under the Plan. Benefits for Newborn Children apply only to a Child born to a Plan Participant or their Spouse.

Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of placement in Your home for the purpose of adoption or the date of an entry of an interim court order granting You temporary custody of the child, whichever comes first. A notice of placement for adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate upon the expiration of the initial 31, day period. Coverage for an adopted child is not guaranteed, and subject to a health statement. If approved, any applicable pre-existing condition limitation will apply.

TERMINATION DATE OF INSURANCE:

Plan Termination Date

Termination takes effect at 11:59 P.M. on the date of termination. Termination by the Plan Participant or by the Company will be without prejudice to any claims originating prior to the date of termination.

The Plan terminates automatically on the earlier of:

1) The Plan Expiration Date shown in the Plan; or
2) The premium due date if premiums are not paid when due, subject to any grace period.

Failure by the Plan Participant to pay all required premiums due by the last day of the grace period shall be deemed notice by the Plan Participant to the Company to terminate the Plan on the last day of the period for which premiums have been paid.

The Plan may be terminated by the Plan Participant or the Company as of any premium due date by giving written notice to the other and the Participating Organization at least 31 days prior to such date.

The Plan Participant and the Company may terminate the Plan at any time by written mutual consent.

If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Plan Participant will owe the Company the difference.

Plan Participant's Termination Date for all other Coverages:

Insurance for a Plan Participant will end on the earliest of:

1) The date He is no longer in an Eligible Class; or
2) The date the Plan Participant returns to his or her Home Country unless otherwise covered under the Plan; or;
3) The date shown on the Evidence of Coverage issued by the Company or
4) The date the Plan Participant becomes a permanent resident of the United States or;
5) The date He reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
   a) The date the premium is fully earned; or
   b) The Expiration Date of the Plan.

   This does not include Reserve or National Guard duty for training;
6) The end of the period for which the last premium contribution is made; or

7) The date the Plan is terminated; or

8) The date the Plan Participant requests, in writing, that his/her coverage be terminated; or

9) The date the Plan Participant's participation in the Program terminates; or

10) The date the Plan Participant's Trip is completed.

Dependent's Termination Date

A Dependent's coverage under the Plan ends on the earliest of:

1) The date the Plan terminates; or

2) The date the Plan Participant's coverage ends; or

3) The date the Dependent is no longer a Dependent; or

4) The last day of the period for which premiums have been paid.

PREMIUM PROVISIONS

Grace Period:

A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period provided the Plan Participant pays all the premiums due by the last day of the grace period, unless notice has been sent, in accordance with the TERMINATION provision, of the intent to terminate coverage under the Plan. Coverage will end if the premium is not paid by the end of the grace period.

Changes in Premium Rate

The Company may change the premium rates from time to time with at least 31days advanced written or authorized electronic notice. Notice will be sent to the Plan Participant's most recent address in Our records.

However, the Company reserves the right to change rates at any time if any of the following events occur:

1) A change in the terms of the Plan.

2) A subsidiary, division, affiliated organization or eligible class is added or deleted to the Plan.

3) A change in the factors bearing on the risk assumed.

4) A misrepresentation in the information relied on in establishing the rate for the Plan

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.

Reinstatement

The Plan may be reinstated within 31 days of lapse if it is lapsed for nonpayment of premium, if the Plan Participant submits written application to the Company, the Company accepts the application and the Plan Participant makes payment of all overdue premiums.

SCOPE OF COVERAGE

Benefits are payable under the Plan for Eligible Expenses incurred by a Plan Participant for the items stated in the, Schedule of Benefits. Benefits will be payable to either the Plan Participant or the Service Provider for Eligible Expenses incurred Worldwide**,** outside the Plan Participant's Home Country.

The charges enumerated herein will in no event include any amount of such charges which are in excess of Usual, Reasonable and Customary charges. If the charge incurred is in excess of such average charge such excess amount will not be recognized as an Eligible Expense. All charges will be deemed to be incurred on the date such services or supplies, which give rise to the expense or charge, are rendered or obtained.

We will provide the benefits described in the Plan to all Plan Participants who suffer a Covered Loss which:

1) Is within the scope of the **DESCRIPTION OF BENEFITS PROVISIONS**; and
2) Occurs while the person is a Plan Participant under the Plan.

Terms of Payment for Benefits:

Full Excess Medical Expense:

If an Injury or Sickness to the Plan Participant results in his incurring Eligible Expenses for any of the services in the SCHEDULE OF BENEFITS, We will pay the Eligible Expenses incurred, subject to any applicable Deductible Amount, Benefit Period, Co-Payment, and Coinsurance Percentage, that are in excess of Expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The Plan Participant must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for the treatment of a covered Injury or Sickness:

1) While the person is a Plan Participant under the Plan; or
2) During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Expense must be incurred within the time frame shown on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under the Plan is shown on the SCHEDULE OF BENEFITS and

is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

Failure by a Plan Participant to follow the terms and conditions and/ or failure to utilize the network providers and facilities of His primary coverage will result in a benefit reduction of Eligible Expense to 40% of the amount otherwise payable under the Plan. This limitation will not apply to emergency treatment required within 24 hours after an Accident when the Accident occurs outside the geographic area served by Your primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.

DESCRIPTION OF BENEFITS

PART A: ACCIDENT BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS 24-Hour (Other than Air Flight) ACCIDENTAL DEATH AND DISMEMBERMENT

If, within one year from the date of an Accident or Injury covered by the Plan that occurs during the Plan Participant's Trip, the Plan Participant suffers from a Covered Loss listed below, We will pay the percentage

of the Principal Sum set opposite the loss in the table below other than while covered for Air Flight Only Benefits. If the Plan Participant sustains more than one such Loss as the result of one Accident, We will pay only one amount, the largest to which he is entitled. This amount will not exceed the Principal Sum which applies for the Plan Participant. The Principal Sum is the Maximum Benefit Amount shown in Schedule of Benefit.

Benefits are payable if such Injury:

1) Occurs during the course of time the Plan Participant is covered under the Plan;

Loss of:	**Benefit: (Percentage of Principal Sum)**
Loss of Life	100%
Loss of Both Hands or Feet, or Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand or Foot and Entire Sight of One Eye	100%
Loss of One Hand or Foot	85%
Loss of Sight of One Eye	85%

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint.

Severance means the complete separation and dismemberment of the part from the body.

Loss of sight means total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

EXPOSURE TO THE ELEMENTS OR DISAPPEARANCE

Subject to all other terms and conditions of the Plan, We will:

1) Pay the applicable benefit under **BENEFITS FOR ACCIDENTAL DEATH AND DISMEMBERMENT** for a Plan Participant's loss specified therein, which results from unavoidable exposure to the elements or disappearance due to:
   a) The forced landing; stranding; sinking; or wrecking of a vehicle in which a Plan Participant was traveling; and
   b) Such Occurrence occurs from an Accident for which the Plan provides coverage; or
2) Presume that a Plan Participant has died if:
   a) A vehicle in which he is traveling disappears; sinks; is stranded; or is wrecked; as a result of an Accident for which the Plan provides coverage; and
   b) His body is not found within one year of the Occurrence of (2)(a) above.

These benefits will not duplicate any other benefits payable under the Plan Participant’s Evidence of Coverage or any coverage(s) attached to the Plan Participant’s Evidence of Coverage.

ACCIDENT and SICKNESS MEDICAL EXPENSE BENEFITS

We will pay Accident and Sickness Medical Expense Benefits for Eligible Expenses. These benefits are subject to the Deductibles, Co-Payment, Coinsurance Factors, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident and Sickness Medical Expense Benefits are only payable:

1) for Usual, Reasonable and Customary Charges incurred after the Deductible has been met;
2) for those Medically Necessary Eligible Expenses incurred by or on behalf of the Plan Participant;

No benefits will be paid for any expenses incurred that are in excess of Usual, Reasonable and Customary Charges.

Eligible Medical Expenses include:

1) **Hospital Admission Expenses:** Charges for each hospital admission.
2) **Outpatient Pre-Surgical Testing benefit** – charges for Pre-surgical testing. A scheduled surgical procedure must occur within 7 days of the testing.
3) **Nursing Services** – Outpatient Charges for nursing services by a Registered Nurse or Licensed Professional.
4) **Skilled Nursing Facility** - charges for services as described in the schedule of benefits. The benefit provides skilled nursing 24 hours a day, seven days a week, under the supervision of a registered nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A SNF provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence.

   A SNF confinement must take place within 14 days from a hospital discharge and must represent care for the same condition which required hospitalization that lasted a minimum of three days. Care may not be custodial in nature (e.g., care which could be performed at home). The facility may not be primarily a place which provides general care for the aged.
5) **Hospice Care Benefit** as follows:
   a) nursing care by a Registered Nurse; or a licensed practical Registered Nurse, a vocational Registered Nurse, or a public health Registered Nurse who is under the direct supervision of a Registered Nurse;
   b) physical therapy and speech therapy when rendered by a licensed therapist;
   c) medical supplies, including drugs and the use of medical appliances;
   d) physician's services; and
   e) services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.
6) Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.
7) Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items.

ADDITIONAL BENEFITS

HOSPITAL ROOM & BOARD BENEFIT

We will pay charges for the most common semi-private daily room rate for each day of the Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge. Hospital Room and Board expenses will include floor nursing while confined in a ward or semi-private room of a Hospital and other Hospital services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's average charge for semiprivate room and board accommodation.

INTENSIVE CARE/CARDIAC CARE UNIT BENEFIT

We will pay charges for each day of Intensive Care/Cardiac Care Unit confinement, up to the Daily Maximum Benefit shown in the schedule per day. This payment is in lieu of payment for the Hospital Room and Board charges for those days and includes nursing services.

HOSPITAL MISCELLANEOUS EXPENSE BENEFIT

We will pay for services, supplies and charges during a Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule per day. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies; and blood and blood transfusions. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items

EXTENDED CARE FACILITY SERVICES, SKILLED NURSING AND INPATIENT REHABILITATION

Benefits are provided for an Inpatient confinement and services provided in an approved extended care facility following, or in lieu of, an Admission to a Hospital as a result of a covered Illness, disability or Injury. Care provided must be at a skilled level and is payable in accordance with the current Schedule of Benefits. Intermediate, custodial, rest and homelike care services will not be considered skilled and are not covered. Coverage for confinement is subject to Insurer approval. Covered services include the following:

- Skilled nursing and related services on an inpatient basis for patients who require medical or nursing care for a covered Illness. A confinement includes all approved extended care facility Admissions not separated by at least 180 days.
- Rehabilitation for patients who require such care because of a covered Illness, disability or Injury.

SURGEON (IN OR OUTPATIENT) BENEFITS

We will pay charges for:

1) A Physician, for primary performance of a surgical procedure, up to the Maximum Benefit Amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Eligible Expenses for the additional surgeries.
2) A Physician, for assistant surgeon duties up to the Maximum Benefit shown in the Schedule of Benefits.

PRE-ADMISSION TESTING BENEFIT

We will pay benefits for charges for Pre-admission testing (inpatient confinement must occur within 3 days of the testing).

ANESTHESIA BENEFIT

We will pay benefits for Anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.

DAY SURGERY MISCELLANEOUS BENEFIT

We will pay Day Surgery Miscellaneous benefits for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs or medicine; therapeutic services; and supplies, on an outpatient basis.

DIAGNOSTIC X-RAY AND LABORATORY BENEFIT

We will pay the benefit if the Plan Participant requires diagnostic x -ray and/or laboratory examinations and services due to a Covered Loss, up to the Maximum Benefit per Covered Accident or Sickness indicated in the Schedule of Benefits. Outpatient x-ray services and laboratory tests are limited to the amount shown in the Schedule of Benefits.

AMBULANCE BENEFIT

When, by reason of Injury or Sickness, a Plan Participant requires the use of a community or Hospital Ambulance in a Medical Emergency, We will pay a Benefit Amount up to a Maximum shown in the schedule, within the metropolitan area in which the Plan Participant is located at that time the service is used. Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, the scene of the Accident or Medical Emergency to a Hospital or between Hospitals. Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area

Air transportation is covered when Medically Necessary because of a life-threatening Injury or Sickness or if the Plan Participant is in a rural area, then air ambulance transportation to the nearest metropolitan area will be considered an Eligible Expense. Air Ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

PHYSICIAN VISIT BENEFIT (INPATIENT)

We will pay charges by a Physician for other than pre- or post-operative care for in-Hospital visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.

PHYSICIAN VISIT BENEFIT (OUTPATIENT)

We will pay charges by a Physician for office visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Office Visits.

Total visits per Injury will not exceed the combined Maximum shown in the Schedule of Benefits for All In-Hospital and Office Physician's Visits.

CONSULTANT PHYSICIAN BENEFIT

If, by reason of Injury or Sickness, a Plan Participant requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending Physician for the purpose of confirming or

determining a diagnosis, We will pay the Covered Percentage of the Covered Expenses incurred.

RADIATION/ CHEMOTHERAPY THERAPY EXPENSE BENEFIT

We will pay the Covered Percentage for the Covered Expenses incurred by a Plan Participant for drugs used in antineoplastic therapy and the cost of its administration. Coverage is provided for any drug approved by the Federal Food and Drug Administration (FDA), regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug was approved by the FDA, so long as:

1) the drug is ordered by a Physician for the treatment of a specific type of neoplasm;
2) the drug is approved by the FDA for use in antineoplastic therapy;
3) the drug is used as part of an antineoplastic drug regimen;
4) current medical literature substantiates its efficacy, and recognized oncology organizations generally accept the treatment; and
5) the Physician has obtained informed consent from the patient for the treatment regimen that includes FDA approved drugs for off-label indications.

EMERGENCY ROOM BENEFIT

We will pay this benefit if the Plan Participant requires Emergency Room treatment due to a Covered Loss resulting directly and independently of all other causes from a Covered Accident or Sickness.

Emergency Room means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.

Services including physician charges and related x-ray/laboratory interpretations will be paid under this benefit.

WELLNESS MEDICAL EXPENSE BENEFIT:

We will pay Eligible Expenses, as per the limits stated in the Schedule of Benefits, Sickness Medical. Coverage is limited to the following expenses incurred subject to Exclusions. This benefit is not subject to Deductible or Coinsurance. In no event will the Company's maximum liability exceed the maximum stated in Section II, Schedule of Benefits, Sickness Medical, as to expenses during any one period of individual coverage. Covered wellness expenses include:

Child Wellness: Benefits are provided for well-child routine medical exams, routine eye exams, routine hearing exams, health history, development assessments, immunizations, and age-related diagnostic tests covered up to the age of 12 months.

Adult Wellness: Benefits are provided for routines physical examinations, routine eye exams, routine hearing exams, immunizations for infectious diseases as recommended by the Center for Disease Control and preventive medical attention.

MATERNITY AND PRE-NATAL CARE BENEFIT

When a covered Maternity is incurred by a Plan Participant the Company will pay the Usual, Reasonable and Customary medical expenses in excess of the Deductible and Coinsurance as stated in the Schedule of Benefits, Maternity. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits Maternity, as to Eligible Expenses during any one period of individual coverage.

Benefits will be payable for Eligible Expenses a Plan Participant incurs before, during, and after delivery of a Child, including Physician, Hospital, laboratory, and ultrasound services. Coverage for the Inpatient postpartum stay for the Plan Participant and her newborn Child in a Hospital, will, at a minimum, be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their guidelines for Perinatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the Plan Participant Person's attending Physician determines further Inpatient postpartum care in not necessary for the Plan Participant or her newborn Child provided the following are met:

1) In the opinion of the Plan Participant Person's attending Physician, the newborn Child meets the criteria for medical stability in the guidelines for Perinatal Care prepared by the Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of:
   a) The antepartum, intrapartum, postpartum course of the mother and infant;
   b) The gestational stage, birth weight, and clinical condition of the infant;
   c) The demonstrated ability of the mother to care for the infant after discharge; and
   d) The availability of post discharge follow-up to verify the condition of the infant after discharge; and
2. One (1) at-home post-delivery care visit is provided to the Plan Participant at her residence by a Physician or Registered Nurse performed no later than forty-eight (48) hours following discharge of the Plan Participant and her newborn Child from the Hospital. Coverage for this visit includes, but is not limited to:
   a) Parent education;
   b) Assistance in training in breast or bottle feeding; and
   c) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the Plan Participant or newborn Child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. (At the Plan Participant Person's discretion, this visit may occur at the Physician's office.)

MENTAL AND NERVOUS CONDITIONS EXPENSE BENEFIT

If a Plan Participant requires treatment for a Mental or Nervous Condition, We will pay for such treatment as follows:

BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT

When a Plan Participant requires Hospital Confinement for treatment of a Mental or Nervous Condition, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement.

Such confinement must be in a licensed or certified facility, including Hospitals.

BENEFITS FOR OUTPATIENT SERVICES

We will pay the Covered Percentage of the Eligible Expenses incurred for the outpatient treatment of Mental and Nervous Conditions as defined up to one visit per day.

The Mental and Nervous Condition must, in the professional judgment of healthcare providers, be treatable, and the treatment must be Medically Necessary.

Outpatient treatment and Physician services include charges made by an outpatient treatment department of a Hospital, or community mental health facility, or charges for services rendered in a Physician's office.

Treatment may be provided by any properly licensed Physician, psychologist or other provider as required by law.

Biologically Based Mental Sickness means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Sickness.

We will pay the Covered Percentage of the Eligible Expenses incurred for treatment of biologically based mental Sickness, including:

a) Schizophrenia;
b) Schizoaffective disorder;
c) bipolar affective disorder;
d) major depressive disorder;
e) specific obsessive-compulsive disorder;
f) delusional disorders;
g) obsessive compulsive disorders;
h) anorexia and bulimia; and
i) panic disorder.

ALCOHOL AND DRUG ABUSE EXPENSE BENEFIT

If a Plan Participant requires treatment on account of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay for such treatment as follows:

BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT

When a Plan Participant is confined as an inpatient in: (i) a Hospital; or (ii) a Detoxification Facility for the treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement.

Such Confinement must be in a licensed or certified facility, including Hospitals.

BENEFITS FOR OUTPATIENT SERVICES

We will pay the Covered Percentage of the Eligible Expenses incurred for the treatment of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency.

Outpatient Treatment and Physician services include charges for services rendered in a Physician's office or by an outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the Hospital, community mental health facility or alcoholism treatment facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by or under the clinical supervision of a licensed Physician or a licensed psychologist who certifies that a Plan Participant needs to continue such treatment.

Alcohol Abuse means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Drug Abuse means a condition that is characterized by a pattern of pathological use of a drug with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Detoxification Facility means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social and emotional needs of the individual by:

a) monitoring the amount of alcohol and other toxic agents in the body of the individual;
b) managing withdrawal symptoms; and
c) motivating the individual to participate in the appropriate addiction's treatment programs for Alcohol and Drug Abuse.

ELECTIVE/THERAPEUTIC TERMINATION OF PREGNANCY BENEFIT

We will pay benefits as described in the Schedule of Benefits for expenses incurred for the intentional termination of pregnancy before the fetus can live independently.

EMERGENCY DENTAL EXPENSE BENEFIT

We will pay benefits as described in the Schedule of Benefits for expenses for emergency dental treatment due to Injury to natural teeth.

PHYSIOTHERAPY EXPENSE BENEFIT

We will pay benefits as described in the Schedule of Benefits for eligible Physiotherapy expenses incurred by the Plan Participant. We will pay Usual, Reasonable and Customary expenses in excess of the Deductible as stated in the Schedule of Benefits. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Expenses during any one period of individual coverage.

For the purpose of this section, **Physiotherapy means c**harges for physiotherapy if recommended by a Physician for the treatment of a specific Disablement and administered by a licensed physiotherapist as an inpatient or outpatient, up to up to the maximum amount shown in the Schedule of Benefits per day for the Outpatient Physiotherapy benefit.

Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic, adjustments, manipulation, acupuncture, cardiac rehabilitation, vocational and speech therapy, or any form of physical therapy.

DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, a Plan Participant requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Eligible Expenses incurred by a Plan Participant for such Durable Medical Equipment. We pay the Covered Percentage of the Eligible Expenses incurred by a Plan Participant for the purchase or rental of such item. In no event shall we pay rental charges in excess of the purchase price. Any rental charges paid will be applied toward the cost of the purchase price if the equipment is purchased at a later date**.** If Durable Medical Equipment is purchased, it is Our property and is to be returned to Us, at Our expense, upon completion of a Plan Participant's need, if so requested by Us.

We do not pay for the replacement of Durable Medical Equipment.

Durable Medical Equipment means medical equipment that:

1) is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;

2) can withstand long-term repeated use without replacement;

3) is not useful in the absence of an Injury or Sickness and

4) can be used in the home without medical supervision.

ALLERGY TESTING AND TREATMENT

Benefits are provided for specific allergy testing and allergy immunotherapy that is medically necessary with clinically significant allergic symptoms. Coverage is provided for testing and treatment including allergy serums and injections administered in a Physician's office.

TRANSPLANT SERVICES (HUMAN ORGAN, BONE MARROW, BLOOD & STEM CELL)

Benefits are provided for Medically Necessary blood, organ, or cell transplants and services may be covered. In the United States, the use of the Institutes of Excellence for Transplants approved by GBG is mandatory. This transplant benefit begins once the need for transplantation has been determined by a Physician and has been certified by a second surgical or medical opinion, and includes:

- Pre-transplant care, including those services directly related to evaluation of the need for transplantation, evaluation of the insured for the transplant procedure, and preparation and stabilization of the insured for the transplant procedure.
- Pre-surgical workup including all laboratory and X-ray exams, CT scans, Magnetic Resonance Imaging (MRI's), ultrasounds, biopsies, scans, medications and supplies.
- The hospitalization, surgeries, Physician and surgeon's fees, anesthesia, medication and any other treatment necessary during the transplant procedure.
- Post-transplant care including, but not limited to any Medically Necessary follow-up treatment resulting from the transplant and any complications that arise after the transplant procedure, whether a direct or indirect consequence of the transplant.
- Medication or therapeutic measures used to ensure the viability and permanence of the transplanted organ, cell or tissue.
- Home healthcare, nursing care (e.g. wound care, infusion, assessment, etc.), emergency transportation, medical attention, clinic or office visits, transfusions, supplies, or medication related to the transplant.

Donor search and donor medical services are not covered under the transplant benefit. Storage of bone marrow, stem cell, or other tissue or cell, and all expenses for cryopreservation of more than 24 hours are also excluded.

VOLUNTARY HIV SCREENING

Benefits are provided for the cost of a voluntary HIV screening test performed on an Insured while the Insured is receiving emergency medical services, other than HIV screening, at a hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the Medical Emergency which caused the Insured to seek emergency services. Benefits include one emergency department HIV screening test, the cost of administering such test, all laboratory expenses to analyze the test, the cost of communicating to the Insured the results to the test and any applicable follow-up instructions for obtaining healthcare and supportive services.

HABILITATIVE SERVICES FOR THE TREATMENT OF CONGENITAL OR GENETIC BIRTH DEFECTS

Benefits will be paid the same as any other Sickness for Habilitative Services for the treatment of Congenital or Genetic Birth Defects for a Plan Participant to age 21 years. Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Plan.

For the purpose of this benefit:
Congenital or Genetic Birth Defect means a defect existing at or from birth including a hereditary defect including autism or an autism spectrum disorder or cerebral palsy.

Habilitative Services include occupational, physical, and speech therapy for the treatment of a child with a Congenital or Genetic Birth Defect to enhance the individual's ability to function

AIDS/HIV

Benefits are provided for Medically Necessary, non-experimental services, supplies and medications for the treatment of Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV +), AIDS Related Complex (ARC), sexually transmitted diseases and all related conditions.

PEDIATRIC DENTAL SERVICES

Benefits are provided for Covered Dental Services for a Plan Participant under the age of 19.

Diagnostic Services:

- Intraoral Bitewing Radiographs (Bitewing X-ray)
  Limited to 1 series of films per 12 months
- Panorex Radiographs (Full Jaw X-Ray) or Complete Series
- Radiographs (Full Set of X-Rays)
  Limited to 1 time per 36 months
- Periodic Oral Evaluation (Checkup Exam)
- Limited to 2 times per 12 months. Covered as a separate benefit only if no other services were done during the visit other than X-rays.

Preventive Services:

- Dental Prophylaxis (cleanings)
  Limited to 2 times per 12 months
- Fluoride Treatments
  Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.
- Sealants (Protective Coating)
  Limited to once per first or second permanent molar every 36 months
- Space Maintainers (Spacers)
  Benefit includes all adjustments within 6 months of installation

Minor Restorative Services, Endodontics, Periodontics, and Oral Surgery:

- Amalgam Restorations (Silver Fillings)
  Multiple restorations on one surface will be treated as a single filling.
- Composite Resin Restorations (Tooth Colored Fillings)
  For Anterior (front) teeth only
- Endodontics (Root Canal Therapy)
- Periodontal Surgery
  Limited to one quadrant or site per 36 months per surgical area
- Scaling and Root Planing (Deep Cleanings)
  Limited to 1 time per quadrant per 24 months
- Periodontal Maintenance (Gum Maintenance)

Limited to 4 times per 12-month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement
- Simple Extractions (simple tooth removal)
  Limited to 1 time per tooth of lifetime
- Oral Surgery, including Surgical Extraction

Adjunctive Services:
- General Services (including Dental Emergency treatment)
- Covered as a separate benefit only if no other service was done during the visit other than X-rays
- General anesthesia is covered when clinically necessary
- Occlusal guards limited to 1 guard every 12 months

Major Restorative Services:
Replacement to complete dentures, fixed, or removable partial dentures, crowns, inlays, or onlays previously submitted for payment is limited to 1 time per 60 months from initial or supplemental placement
- Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.
- Fixed Prosthetics (bridges) Limited to 1 time per 60 months. Covered only when a filling cannot restore the tooth.
- Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments
- Relining and Rebasing Dentures Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.

Implants:
- Implant Placement Limited to 1 time per 60 months
- Implant Supported Prosthetics Limited to 1 time per 60 months
- Implant Supported Prosthetics Limited to 1 time per 60 months
- Implant Maintenance Procedures Includes removal of prosthesis, cleansings of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.
- Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months
- Abutment Supported Crown (Titanium) or Retainer Crown for FPD-Titanium Limited to 1 time per 60 months
- Repair Implant Abutment by Support Limited to 1 time per 60 months
- Repair Implant Abutment by Support Limited to 1 time per 60 months
- Radiographic/Surgical Implant by Report Limited to 1 time per 60 months

Medically Necessary Orthodontics
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy, or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefit are not available for comprehensive orthodontic and/or having horizontal/vertical (overjet/overbite) discrepancies.

All orthodontic treatment must be Pre-Authorized.

Orthodontic Services:

- Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be Medically Necessary.

EMERGENCY MEDICAL EVACUATION, MEDICAL REPATRIATION AND RETURN OF REMAINS

When You suffer loss of life for any reason or incur a Sickness or Injury during the course of Your Trip, the following benefits are payable, up to the Maximum Benefit Amount shown in the Schedule of Benefits.

1) Emergency Medical Evacuation: If the local attending Legally Qualified Physician and the Program Medical Advisor determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment.
2) Medical Repatriation: If the local attending Legally Qualified Physician and the Program Medical Advisor determine that it is Medically Necessary for You to return to Your primary place of residence because of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred within 30 days from the date of the Covered Loss, will be paid for Your return to Your primary place of residence or to a Hospital or medical facility closest to Your primary place of place of residence capable of providing continued treatment via one of the following methods of transportation, as approved, in writing, by the Program Medical Advisor:
    a) one-way Economy Transportation;
    b) commercial air upgrade (to Business or First Class), based on Your condition as recommended by the local attending Legally Qualified Physician and verified in writing and considered necessary by the program Medical Advisor; or
    c) other covered land or air transportation including, but not limited to, commercial stretcher, medical escort, or the Usual and Customary Charges for air ambulance, provided such transportation has been pre-approved and arranged by the Program Medical Advisor. Transportation must be via the most direct and economical route.
3) Return of Remains: In the event of Your death during a Trip, the expense incurred within 30 days from the date of the Covered Loss will be paid for minimally necessary casket or air tray, preparation and transportation of Your remains to Your Home Country or to the place of burial.

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses, subject to the Deductible Amount, co-payment, and Coinsurance Percentage shown in the Schedule of Benefits, if any; for a Prescription Drug or medication when prescribed by a Physician on an outpatient basis.

Prescription Drug means a drug which:

1) Under Federal law may only be dispensed by written prescription; and
2) Is utilized for the specific purpose approved for general use by the Food and Drug Administration.

The Prescription Drug must be dispensed for the outpatient use by the Plan Participant:

1) On or after the Plan Participant's Effective Date; and

2) By a licensed pharmacy provider.

Benefits are payable up to the Maximum Benefit Amount shown on the Schedule of Benefits.

EXCLUSIONS

The Plan does not cover any loss resulting from any of the following unless otherwise covered under the Plan by Additional Benefits:

1) Suicide, attempted suicide (including drug overdose) self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane;

2) War or any act of war, declared or undeclared;

3) An Accident which occurs while the Plan Participant is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;

4) Injury sustained while in the service of the armed forces of any country. When the Plan Participant enters the armed forces of any country, We will refund the unearned pro rata premium upon request;

5) Voluntary, active participation in a riot or insurrection;

6) Commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal occupation;

7) Eligible Expenses for which the Plan Participant would not be responsible in the absence of the Policy;

8) Treatment of acne;

9) Charges which are in excess of Usual, Reasonable and Customary charges;

10) Charges that are not Medically Necessary;

11) Charges provided at no cost to the Plan Participant;

12) Expenses incurred for treatment while in Your Home Country;

13) Expenses incurred for an Accident or Sickness after the Benefit Period shown in the Schedule of Benefits or incurred after the termination date of coverage;

14) Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in an occupation for monetary gain

15) Benefits for 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;

16) Pregnancy or childbirth, except when conception occurs while covered under the Policy; elective cesarean section; or any complications of any of these conditions; pregnancy or childbirth or a dependent when dependent child of an Plan Participant (except for complications arising there from) except as stated in the Summary of Benefits;

17) 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 except as stated in the Summary of Benefits;

18) Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes;

19) Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Plan Participant is covered under the Plan, and rendered within 6 months of the Accident except as covered under the Pediatric Dental Services Benefit;

20) Eyeglasses, contact lenses, hearing aids braces, appliances, or examinations or prescriptions therefore except as covered under the Pediatric Vision Benefit

21) Weak, strained or flat feet, corns, calluses, or toenails;

22) Travel in or upon:

(a) A snowmobile;

(b) A water jet ski

(c) Any two or three wheeled motor vehicle;

(d) Any off-road motorized vehicle not requiring licensing as a motor vehicle; when used for recreation competition.

23) Injury sustained while taking part in: mountaineering; hang gliding; parachuting; bungee jumping; racing by horse; snowmobiling; motorcycle/motor scooter riding; scuba diving, involving underwater breathing apparatus; scuba diving, involving underwater breathing apparatus; snorkeling; water skiing; snow skiing; spelunking; parasailing; white water rafting; surfing, unless part of a school credit course; and snowboarding.

24) Practice or play in any, professional or semi-professional sports contest or competition, traveling to or from such sport, contest, or competition as a participant, or while participating in any practice or conditioning program for such sport, contest, or competition;

25) Rest cures or custodial care;

26) Elective or Cosmetic surgery and Elective Treatment or treatment for congenital anomalies (except as specifically provided), except for reconstructive surgery on a diseased or injured part of the body (Correction of a deviated nasal septum is considered cosmetic surgery unless it results from a covered Injury or Sickness);

27) Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:

a) While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or

b) While being used for any test or experimental purpose; or

c) While piloting, operating, learning to operate or serving as a member of the crew thereof; or

d) while traveling in any such Aircraft or device which is owned or leased by or on behalf of, or by the Plan Participant or any member of his household.

e) A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or

f) An ultra light, hang-gliding, parachuting or bungee-cord jumping;

Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private aircraft used for business or pleasure purposes.

28) Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste, from combustion of nuclear fuel, the radioactive, toxic, explosive or other hazardous properties of any nuclear assembly or nuclear component of such assembly;

29) Plan Participant being exposed to the Utilization of nuclear, chemical or biological weapons of mass destruction.

Pediatric Dental Exclusion: In addition to the Exclusions and Limitations shown above, the following exclusions also pertain to the Pediatric Dental:

1) Any Dental Service or Procedure not listed in the Schedule of Benefits for Pediatric Dental Services.
2) Dental Services that is not necessary.
3) Hospitalization or other facility charges.
4) Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5) Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6) Any Dental Procedure not directly associated with dental disease.
7) Any Dental Procedure not performed in a dental setting.
8) Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9) Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10) Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11) Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12) Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly relation to provider error. This type of replacement is the responsibility of the Dental Provider If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13) Charges for failure to keep a scheduled appointment with giving the dental office 24 hours' notice.
14) Expenses for Dental Procedures begun prior to the Plan Participant's Effective Date of coverage.
15) Dental Services rendered after the date of individual coverage under the Plan terminates, including Dental Services for dental conditions arising prior to the date the plan terminates.
16) Services rendered by a provider with the same legal residence as the Plan Participant or who is a member of the Plan Participant's family, including spouse, brother, sister, parent or child.
17) Foreign services are not covered unless required for a Dental Emergency.
18) Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
19) Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

20) Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.

CLAIM PROVISIONS

NOTICE OF CLAIM:

Written notice of death, or Injury or Sickness must be given to Us within 30 days after a Covered Loss occurs or begins or as soon as reasonably possible. Notice can be given to Our authorized licensed agent. Notice should include the Plan Participant's name and address.

If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

1) it can be shown that it was not possible within reason to submit notice within the 30-day period; and
2) it is further shown that notice was given as soon as possible.

CLAIM FORMS:

When We receive the notice of claim, We will send forms for filing proof of loss. If claim forms are not sent within 15 days after receipt of such notice, the Proof of Loss requirements stated below will be deemed to have been met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:

Written proof of loss must be furnished to Us in the case of a claim for loss for which the Plan provides periodic payment contingent upon continuing loss within 60 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to Us at intervals required by us.

In case of claim for any other loss, proof must be furnished within 60 days after the date of such loss.

If the proof of loss is not submitted within 60 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

1) it can be shown that it was not possible within reason to submit notice within the 60-day period; and
2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS:

Benefits due under the Plan for a loss, other than a loss for which the Plan provides installments, will be paid within 30 days after Our receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for loss for which the Plan provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid within 30 days after Our receipt of a written proof of loss, unless otherwise stated in the Description of Benefits.

Failure to pay claims within 30 days shall entitle the claimant to interest at the rate of 9 per cent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. A claimant or their assignee shall be notified by Us of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim. Any required interest payments shall be made within 30 days after the payment.

PAYMENT OF CLAIMS:

All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of the Plan.

All other benefits will be paid to the Plan Participant suffering the loss. If the Plan Participant dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of the Plan.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to $1,000 to a relative by blood or marriage whom We believe is equitably entitled. This good faith payment satisfies Our legal duty to the extent of that payment.

Any other accrued benefits which are unpaid at a Plan Participant's death may, at Our option, be paid either to his beneficiary or to his estate.

DESIGNATION OR CHANGE OF BENEFICIARY:

Each Plan Participant may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order:

1) Beneficiaries designated in writing by the Plan Participant for the Plan on file, if any, otherwise;
2) Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Plan Participant, if any, otherwise;
3) In equal shares to the members of the first surviving class of those that follow, if any:
    a) a Plan Participant’s lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner;
    b) a Plan Participant’s natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Plan Participant has or had legal guardianship (proof will be required); or
    c) a Plan Participant’s parents, whether natural, step or adoptive; or
    d) a Plan Participant’s Sisters or Brothers, otherwise.
4) The estate of the Plan Participant.

A Plan Participant may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, When a request for designation or change is received it will take effect on the date of its execution, whether or not the Plan Participant is living on the date it is received. Any interest created by the request will be subject to any payment made or action taken before its receipt.

A Dependent’s beneficiary is the Plan Participant. If no beneficiary is living on the date of a Dependent’s death, the beneficiary is the Plan Participant’s estate.

PHYSICAL EXAMINATION AND AUTOPSY:

We have the right to have a Physician of Our choice examine the Plan Participant as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We will pay the cost of the examination.

RECOVERY OF OVERPAYMENT:

If benefits are overpaid or paid in error We have the right to recover the amount overpaid or paid in error by any of the following methods.

1) A request for lump sum payment of the amount overpaid or paid in error or

2) Reduction of any proceeds payable under the Plan by the amount overpaid or paid in error.

RECOVERY OF BENEFITS:

We reserve the right to recover from a Plan Participant any benefits We have paid to him for injuries:

(1) Received in a covered Accident; and

(2) Which are covered under:

(a) workers' compensation or similar statutory remedies available under law; or

b) Any employer's liability Insurance.

It will be assumed that the Plan Participant is in receipt of such benefits unless he gives us proof such benefits have been denied to him.

"Recovery" means monies paid to the Plan Participant through judgment, settlement or otherwise to compensate for all losses caused by the Injury.

RIGHT OF REIMBURSEMENT / SUBROGATION:

If a Plan Participant recovers expenses for Sickness or Injury that occurred due to the negligence of a third party, We have the right to first reimbursement for all benefits We paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the Plan Participant, the Plan Participant's parents if the Plan Participant is a minor, or the Plan Participant's legal representative as a result of that Sickness or Injury. You are required to furnish any information or assistance or provide any documents that We may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the third party admits liability.

We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits We paid for that Sickness or Injury. You are required to furnish any information or assistance or provide any documents that We may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

LEGAL ACTIONS:

No legal action may be brought to recover on the Plan within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:

WORKERS' COMPENSATION INSURANCE:

The Plan is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

PLAN TERMINATION:

We may terminate coverage on or after the anniversary of any premium due date. The Plan Participant may terminate its coverage on any premium due date. Written notice must be given at least 31 days prior to such premium due date.

CLERICAL ERROR:

Clerical error in keeping any records pertaining to the coverage, whether by the Plan Participant or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

ASSIGNMENT:

No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

WAIVER:

Failure of the Company to strictly enforce its rights under the Plan at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

LAW AND JURISDICTION

This Plan and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by, and construed in accordance with, the law of England and Wales.

The courts of England and Wales shall have exclusive jurisdiction over any dispute or claim arising out of or in connection with this Plan or its subject matter or formation (including non-contractual disputes or claims).

COMPLAINTS

At times, You may have a concern You would like to tell Us about or disagree with a decision made regarding Your coverage. You can make a compliant or file an appeal to get help for Your situation. The following procedures must be followed for a complaint to be reviewed.

Who to Contact?
The most important factors in getting Your complaint dealt with as quickly and efficiently as possible are:

- Be sure You are talking to the right person; and
- That You are providing the necessary information.

When You Contact Us
Please provide the following information:

- Your name, telephone number, and email address;

- Your policy and/or claim number and the plan of benefits (medical, travel, disability) You are insured for; and
- Please explain clearly and concisely the reason for Your complaint.

Step One: Making a Complaint
If Your complaint relates to:

1. The sale of the policy You purchased or any information You were given during the sales process:
    a. If You purchased the policy using a broker or other intermediary, please contact them first.
    b. If You purchased the policy directly from Us either from a local representative, using the website, or through a group plan of benefits, please contact Us directly at:

Toll Free	**Phone**	**Email**
+1.866.914.5333 (within the U.S. and Canada)	+1.786.814.4125 (outside the U.S. and Canada)	complaints@gbg.com

    c. You may also submit Your complaint via Our Complaint Form, which may be accessed by visiting Our website and navigating to the Forms page: www.gbg.com/#/oursolutions/forms.
2. A claim for benefits, the terms and conditions of the policy, or other benefit related information:
    a. Complaints related to a claim denial should be submitted as soon as possible. We will review the information and provide a response within four weeks or will request additional time, if needed.
    b. Claims and benefits related complaints should be referred to Our Complaints Department:

Toll Free	**Phone**	**Email**
+1. 877.916.7920 (within the U.S. and Canada)	+1. 949.916.7941 (outside the U.S. and Canada)	customerservice@gbg.com

    c. You may also submit Your complaint via Our Appeal Form, which may be accessed by visiting Our website and navigating to the Forms page: www.gbg.com/#/oursolutions/forms.

GBG Insurance Limited is licensed and regulated by the Guernsey Financial Services Commission under the Insurance Business (Bailiwick of Guernsey) Law, 2002.

We always aim to resolve Your complaint and provide a final response within four weeks, but if it looks like it will take Us longer than this, We will let You know the reasons for the delay and regularly keep You up to date with Our progress.

Step Two: Beyond Your Insurer
If We can't respond fully to Your complaint within three months after You contact Us, or You are unhappy with Our final response, You can refer Your complaint to the Channel Islands Ombudsman (CIFO).

You must contact CIFO about Your complaint within six months of the date of Our final response to Your complaint or CIFO may not be able to review Your complaint. You must also contact CIFO within six years of the event complained about or (if later) two years of when You could reasonably have been expected to become aware that You had a reason to complain.

You may contact CIFO at:

Address	Email	Guernsey local phone
Channel Islands Financial Ombudsman PO Box 114 Jersey, Channel Islands JE4 9QG	complaints@ci-fo.org	+44 (0)1481 722218
	Website	**International phone**
	www.ci-fo.org	+44 1534 748610

Notice of Privacy Practices

This notice describes how personal information about You may be used and disclosed and how You can get access to this information. Please review it carefully.

The confidentiality of Your personal information is of paramount concern to Us. We maintain records of the services we cover (claims), and we also maintain information about You that we have used for enrolment processing. We use these records to administer Your policy benefits and coverage; we may also use these records to ensure appropriate quality of services provided to You and to enhance the overall quality of Our services, and to meet Our legal obligations. We consider this information, and the records We maintain, to be protected personal information. We are required by law to maintain the privacy of personal information and to provide Our insureds with notice of Our legal duties and privacy practices with respect to personal information. This notice describes how We may use and disclose Your personal information. It also describes Your rights and Our legal obligations with respect to Your personal information.

How We May Use or Disclose Your Personal Information

We collect and processes Your personal information as necessary for performance under Your insurance policy or complying with Our legal obligations, or otherwise in Our legitimate interests in managing Our business and providing Our products and services. These activities may include:

1. Use of sensitive information about the health or vulnerability of You, or others involved in Your assistance guarantees, in order to provide the services described in Your insurance policy;
2. Disclosure of personal information about You and Your insurance cover to companies within the GBG group of companies (subject to local laws within each applicable jurisdiction), to Our service Providers and agents in order to administer and service Your insurance cover, for fraud prevention, to collect payments, and otherwise as required or permitted by applicable law;
3. Monitoring and/or recording of Your telephone calls in relation to coverage for the purposes of record-keeping, training and quality control;
4. Technical studies to analyze claims and premiums, adapt pricing, support subscription processes and consolidate financial reporting (including regulatory); detailed analyses on claims/calls to better monitor Providers and operations; analyses of customer satisfaction and construction of customer segments to better adapt products to market needs;
5. Obtaining and storing any relevant and appropriate supporting evidence for Your claim, for the purpose of providing services under Your insurance policy and validating Your claims; and

6. Sending feedback requests or surveys relating to Our services, and other customer care communications.

These activities are carried out within the UK and European Economic Area (EEA), and outside the EEA in countries for which an adequate level of data protection has not yet been determined by the EU Commission. However, we have taken appropriate measures to ensure that your personal data remains protected in accordance with applicable data protection laws, including conclusion of the EU standard contractual clauses for the transfer of personal data. Further details on the appropriate safety precautions taken are available on request and further information is available under website privacy policy under https://www.gbg.com/#/AboutGBG/PrivacyPolicy.

According to the applicable data protection laws, you are entitled, on request, to a copy of the personal information we hold about you, and you have other rights to deletion, correction, object, restriction, data portability in relation to how we use your data (as set out in our website privacy policy under https://www.gbg.com/#/AboutGBG/PrivacyPolicy). Please let us know if you think any information we hold about you is inaccurate, so that we may correct it.

If You have any questions about this Notice of Privacy Practices or Our use of Your personal information You may contact the Data Protection Officer. Contact details are below:

GBG Insurance Limited
Data Protection Officer
Fourth Floor, Albert House
South Esplanade, St Peter Port
Guernsey, GY1 1AW
Email address: dataprotection@gbg.com

SUBSCRIPTION AGREEMENT

I hereby apply to be a Plan Participant of the International Benefit Trust established in the Cayman Islands (the "Trust") and to participate in the insurance coverage extended by GBG Insurance Limited (the "Insurer") to Plan Participants under the Trust (the "Coverage"). I understand that the Coverage is not a general health insurance product, but is intended for use in the event of a sudden and unexpected event while traveling outside my Home Country (for purposes of this Agreement, Home Country means the country from which the Plan Participant holds a passport. In the event that a citizen of the United States holds more than one passport, the United States shall be deemed the Home Country). I understand that the Coverage extended to me will terminate upon my return to my Home Country unless I qualify for a benefit period or Home Country coverage. I understand that I may obtain full details of the Coverage by requesting a copy of the Master Policy from Global Benefits Group (the “Plan Manager”). I understand that the liability of the Insurer as underwriter of the Coverage is as provided in the Master Policy.

By acceptance of coverage and/or submission of any claim for benefits, the Plan Participant ratifies the authority of the undersigned to so act and bind the Plan Participant.

The Plan Participant undertakes to make all premium payments as they fall due in respect of the Coverage extended. ITA Global Trust Ltd (the “Trustee”) shall not be responsible for the administration of such payments. If the Plan Participant fails to make any premium payment due in respect of the Coverage extended, subject to the discretion of the Insurer, such Coverage will lapse.

The Plan Participant hereby confirms the accuracy of all information and validity of all representations and warranties provided to the Trustee in connection with its participation in the Plan and/or the subscription for the insurance coverage, howsoever provided, including the terms of this Subscription

Agreement, (together "Representations & Warranties"). The Plan Participant acknowledges that certain of such information will be relied upon by the Insurer as Provider of the Coverage and that any inaccuracy therein may result in the invalidity of such Coverage as it relates to the Plan Participant, the loss of Coverage and all monies paid in relation thereto. The Plan Participant hereby undertakes to inform the Trustee of any change to any matter that forms the subject of any of the Representations & Warranties. The Plan Participant hereby undertakes to indemnify and hold harmless the Trustee against any loss or damage (including attorney's fees) occasioned by any inaccuracy in any Representations & Warranties or failure to advise the Trustee of any change in any matter that forms the subject of any of the Representations & Warranties. The Plan Participant agrees that the Trustee shall be entitled to rely on and to act in accordance with any written instruction purported to be provided by the Plan Participant and the Plan Participant hereby undertakes to indemnify and hold harmless the Trustee against any loss or damage (including attorney's fees) occasioned by the Trustee acting in accordance with any such instruction.

Payments under the terms of the Coverage shall be paid by the Insurer to the Plan Participant or directly to a Provider if assignment of benefits has been authorized. The Trustee shall not be responsible for the administration of such payments.

I confirm that I have satisfied myself that the Coverage is appropriate for me and that I meet the eligibility criteria.