GBG
Insurance Without Borders℠

Global Student Navy

SUMMARY OF BENEFITS
INTERNATIONAL STUDENT
GROUP COVERAGE

SANTA MARGARITA CATHOLIC HIGH SCHOOL

Welcome! This is a short-term medical Plan intended to provide Accident and Illness coverage while you are temporarily away from your Home Country and studying abroad.

Please keep this Summary of Benefits as an explanation of the benefits available to You under the contract between the Insurer and the Policyholder. This Summary of Benefits is not a contract between You and the Insurer. The Master Policy is on file with the Policyholder and contains all of the provisions, limitations, exclusions, and qualifications of Your insurance benefits, some of which may not be included in this Summary of Benefits. The Master Policy is the contract and will govern and control the payment of benefits.

If your study abroad program has you temporarily residing in the United States, there are requirements and instructions on how to maximize benefits and receive reimbursements for Prescription Medications, Medical claims, and other benefits covered under this Plan. There are also requirements for Pre-Authorization of specified medical care. Dedicated GBG Assist personnel are available to assist you.

- ***Using an In-Network medical Provider in the U.S results in lower out-of-pocket costs to you.*** See the section titled "Preferred Provider Network" for assistance with locating a Provider.
- ***Pre-Authorization is a process for obtaining approval for specified non-emergency, medical procedures or treatments***. Failure to Pre-Authorize when required will result in a reduction in payment by the Insurer. See the section titled, "Pre-Authorization Requirements and Procedures" for more complete details.
- ***Prescription Medications must be obtained from any CVS/Caremark pharmacy***. Present your Medical Identification card to the pharmacist along with the copayment, at the time of purchase.
- ***Hospital Emergency Rooms*** should only be used in medical emergency situations. A medical emergency situation is where your life or health is in jeopardy. Using an emergency room is very expensive. If you using an emergency room for convenience or for any reason other than a serious medical emergency, you will be responsible for a large portion of the payment.

How You Can Reach Us

Customer Service, Pre-Authorization, and Help Locating a Provider (24/7)

- Worldwide Collect +1.786.814.4125
- Inside USA/Canada Toll Free +1.866.914.5333
- Email: GBGAssist@gbg.com
- Website: www.gbg.com

We invite you to visit our Member Services Portal at www.gbg.com, and register as a New Member. The Member Services Portal allows you to conveniently access our Provider Directory, download Forms, submit Claims, and utilize other valuable tools and services.

We look forward to providing you with this valuable insurance protection and outstanding service during your period of study.

THANK YOU FOR SELECTING GLOBAL BENEFITS GROUP STUDENT HEALTH INSURANCE

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GBG Insurance Without Borders™

Global Student Navy

POLICY FACE PAGE

Policyholder	Multi-National Benefit Trust
Participating Organization Name	Santa Margarita Catholic High School
Participating Organization Address	500 Technology Dr, Irvine CA 92618
Plan Number	NVY-18765
Policy Effective Date	01 August 2021
Policy Termination Date	31 July 2022
Dependent Eligibility	Dependents Not Eligible
Currency	USD

SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary outline of the benefits covered under this insurance Plan. The benefits are divided into two sections; Medical Expense Benefits and Non-Medical Expense Benefits. Please read the Description of Benefits sections for full details. All benefits described are subject to the definitions, exclusions and provisions.

ELIGIBLE PERSONS

Eligible Person is an individual who meets all the requirements of one of the covered Classes shown below:

Class 1

A registered Full-time student attending a recognized K-12 institution who is a minimum of 5 years and a maximum of 20 years. Student must have a current passport and be travelling outside their Home County; and student must have a valid F1 visa type.

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MEDICAL EXPENSE BENEFITS

The following Medical Expense Benefits are subject to the Plan Participant's Deductible, Copayment, and Coinsurance amount. After satisfaction of the Deductible and applicable Copayments, the Insurer will pay eligible benefits set forth in this Schedule at the specified Plan Coinsurance and reimbursement level.

GENERAL FEATURES AND PLAN SPECIFICATIONS	
U.S. Provider Network	United Healthcare
Area of Coverage	Worldwide
Home Country Coverage	$500 per Period of Insurance
Maximum Benefit Payable per Period of Insurance • Benefits incurred outside of the U.S. are limited to a maximum of $1,500 per Period of Insurance	Unlimited
Lifetime Maximum	Unlimited
Individual Deductible[1] • In-Network Provider • Out-of-Network Provider	 $0 $500
Office Visit Copayment[2] • In-Network • Out-of-Network	 $20 $50
Emergency Room Copayment[2] (waived if admitted)	$ 300 per Occurrence

[1] The Deductible for In-Network does not accrue towards the Out-of-Network Deductible.

[2] Copayments do not apply to the Deductible or the Out-of-Pocket Maximum.

Out-of-Pocket-Maximum[3]	None Unlimited if an Out-of-Network Provider in the U.S. is used
Pre-Existing Condition Limitation (12-months Lookback Period)	Pre-Existing conditions are covered after a 6-months a Waiting Period

COVERED SERVICES AND BENEFIT LEVELS Subject to Deductible, Coinsurance, Copayment, and Maximum Benefit per Period of Insurance.	**WHAT THE INSURANCE PLAN COVERS** The following Coinsurance applies for In-Network Providers in the U.S. or for expenses incurred outside the U.S. (if available). Coinsurance reduces to 80% UCR when Out-of-Network Providers in the U.S. are used.
HOSPITALIZATION AND INPATIENT BENEFITS	
Accommodations including semi-private room	100% Preferred Allowance
Intensive Care/Cardiac Care	100% Preferred Allowance
Inpatient Consultation by a Physician or Specialist	100% Preferred Allowance
Hospital Miscellaneous Expenses	100% Preferred Allowance
Pre-Admission Testing	100% Preferred Allowance
OUTPATIENT BENEFITS	
Physician Visit/Consultation by Specialist • $20 Copayment Physician/Specialist • $20 Copayment Urgent Care Center • $50 Copayment (Out-of-Network Providers)	100% Preferred Allowance
Diagnostic Testing • X-Ray and Laboratory • MRI, PET, and CT Scans • Office visit Copayment applies when testing is done outside an office visit	100% Preferred Allowance
Therapeutic Services, Physical Therapy, Chiropractic, Occupational Therapy, Vocational and Speech Therapy • Maximum Benefit per Period of Insurance: 12 visits per Injury/Illness • Office visit Copayment applies	100% Preferred Allowance

[3] The Deductible does not apply to the Out-of-Pocket Maximum.

SURGICAL BENEFITS (INPATIENT/OUTPATIENT)	
Inpatient, Outpatient or Ambulatory Surgery **Includes:** • Surgeon's Fees • Out-of-Network Assistant Surgeon or Anesthesiologist (up to 25% of Usual, Reasonable, & Customary for surgery) • Facility fees • Laboratory tests • Medications and dressings • Other medical services and supplies	100% Preferred Allowance
EMERGENCIES	
Emergency Room and Medical Services • $300 Copayment waived, if admitted	100% Preferred Allowance
Ambulance Services • Emergency local ground ambulance • Out-of-Network reimbursed at 100%	100% Preferred Allowance
Emergency Dental • Limited to accidental Injury of sound natural teeth sustained while covered • Maximum Benefit per Period of Insurance: $1,000	100% Preferred Allowance up to $250 per tooth
OTHER BENEFITS (INPATIENT/OUTPATIENT)	
Mental Health • To treat a covered diagnosis • Inpatient Maximum Benefit per Period of Insurance: 30 days • Outpatient Maximum Benefit per Period of Insurance: 40 visits • Office visit Copayment applies	100% Preferred Allowance
Preventive Care and Annual Exams • In-Network or Student Health Center only • Age-appropriate immunizations • One exam, limited to Maximum Benefit per Period of Insurance: $600	100% Preferred Allowance
Chemotherapy, Radiotherapy	100% Preferred Allowance
Home Health Care • Maximum Benefit per Period of Insurance: 100 days	100% Preferred Allowance
Diabetic Medical Supplies • Includes Insulin Pumps and associated supplies	100% UCR
Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV+), AIDS Related Complex (ARC), Sexually transmitted diseases and all related conditions	100% Preferred Allowance

OTHER BENEFITS (INPATIENT/OUTPATIENT) (CONTINUED)	
Durable Medical Equipment • Reimbursement of rental up to the purchase price • Maximum Benefit per Period of Insurance: $10,000	100% UCR
Alcohol and Substance Abuse • Inpatient Maximum Benefit per Period of Insurance: 30 days • Outpatient Maximum Benefit per Period of Insurance: 40 visits • Office visit Copayment applies	100% Preferred Allowance
Prescription Medications • Up to 31-day supply per prescription • CVS/Caremark network pharmacy is required • Maximum Benefit per Period of Insurance: $2,000	100% of charges
Sports Activities • Injuries arising from Interscholastic, Intramural, and Club sports • Maximum Benefit per Period of Insurance: $10,000	100% Preferred Allowance
Passive War and Terrorism	Included

NON-MEDICAL EXPENSE BENEFITS[4]

Compassionate Care Visit • Maximum Benefit per Period of Insurance: $1,000	100%
Medical Evacuation and Repatriation • Maximum Benefit per Period of Insurance: $300,000	100%
Return of Mortal Remains • Maximum Benefit: $50,000	100%
Passport Recovery • Maximum Benefit per Period of Insurance: up to $750	100%
Lost Baggage • Expense reimbursement due to flight delays • $100 Deductible applies • Maximum Benefit per Period of Insurance: $500	100% up to $200 per item

[4] Non-Medical Expense Benefits do not accumulate towards the Medical Expense Maximum Benefit Payable per Period of Insurance or toward the Lifetime Maximum

ACCIDENTAL DEATH AND DISMEMBERMENT

Principal Sum for Primary Plan Participant	$30,000
Time Period for Loss	90 days from the date of the covered Accident
Loss of:	**Benefit: Percentage of Principal Sum**
Accidental Death	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	50%
Loss of Sight of One Eye	50%

1.0 GENERAL PROVISIONS

The **Policyholder** is the Multi-National Benefit Trust, hereinafter shall be referred to as the "Trust".

The **Insurer,** GBG Insurance Limited, hereinafter shall be referred to, sometimes collectively, as the "Insurer", "We" "Us", or "Company".

The declarations of the Participating Organization and Plan Participant in the application serve as the basis for participation in the Trust. If any information is incorrect or incomplete, or if any information has been omitted, the insurance coverage may be rescinded or terminated. Any references in this Certificate to the Plan Participant are expressed in the masculine gender shall be interpreted as including the feminine gender whenever appropriate**.**

No change may be made to this Summary unless it is approved by an Officer of the Insurer. A change will be valid only if made by a Rider signed by an Officer of the Insurer. No agent or other person may change this Certificate or waiver any of its provisions.

This GBG Insurance Limited Plan is an international health insurance Policy issued to the Trust. This insurance shall be governed by the Laws of England and Wales and subject to the exclusive Jurisdiction of the courts of England and Wales, and the Plan Participant should be aware that laws governing the terms, conditions, benefits and limitations in health insurance policies issued and delivered in other countries are not applicable. If any dispute arises as to the interpretation of this document, the English version shall be deemed to be conclusive and taking precedence over any other language version of this document. GBG Insurance Limited is an insurance company incorporated in Guernsey with registration number 42729 and licensed by the Guernsey Financial Services Commission to conduct insurance business under the Insurance Business (Bailiwick of Guernsey) Law, 2002 as amended.

Notwithstanding any other terms under this Plan, the Insurer shall not provide coverage nor make any payments or provide any service or benefit to any Plan Participant, beneficiary, or third party who may have any rights under this Plan to the extent that such cover, payment, service, benefit, or any business or activity of the Plan Participant would violate any applicable trade or economic sanctions law or regulation.

2.0 ELIGIBILITY

2.1 Eligible Classes

All international full-time students enrolled in and attending a recognized K-12 Institution outside of their Home Country; Students must actively attend classes. Home study, correspondence, and online courses do not fulfill the eligibility requirements that the student actively attend class.

Students must actively attend classes. The Insurer has the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If it is discovered the eligibility requirements are not met, the insurance coverage will be terminated.

2.2 Persons Eligible to be a Plan Participant

The Plan Participant on this Plan who is an Eligible Person as identified in the Schedule of Benefits, a Non-United States Citizen travelling outside their Home Country and travelling to the United States and has their true, fixed and permanent home and principal establishment outside of the United States and holds a current and valid passport, and for whom proper Premium payment has been made when due.

Plan Participants are those persons described as an Eligible Class.

Students who are United States citizens are not eligible for coverage.

2.3 Application and Effective Date

The Plan Participant's coverage becomes effective on the Effective Date shown on the Medical Identification Card. Coverage under the Plan ends on the earlier of:

- On the expiration date of the insurance coverage. However, if a Plan Participant's return is delayed due to unforeseeable circumstances beyond their control, the insurance coverage will be extended until such trip can be completed, but no later than seven days from the original insurance coverage expiration, or
- If medical evacuation was necessary, upon the Plan Participant's evacuation to the Home Country.
- Termination of coverage of the Plan Participant also terminates coverage for Dependents.

Note: The minimum Period of Insurance must be the entire duration the Plan Participant actively attends classes.

2.4 Pre-Existing Conditions Limitations

For Plans that include a Waiting Period for Pre-Existing Conditions, the Waiting Period will be reduced by the total number of months that the Plan Participant provides documentation of continuous coverage under prior Creditable Coverage which provided benefits similar to this Plan provided the coverage was continuous to a date within 63 days prior to the Plan Participant's Effective Date.

2.5 Extended Coverage

The Extended Coverage benefit is available to newly enrolled students who arrive in the United States prior to the beginning of the first term of study in the United States, or Plan Participants who have completed their final term of study in the United States and are preparing to return to the Home Country. The Extended Coverage benefit provides up to 30 days of additional coverage.

Extended Coverage does not apply to Plan Participants who are continuing their studies or returning to studies in the United States whether at the same or different institutions.

Newly-Enrolled and Arriving Students

In order to be eligible for the Extended Coverage Benefit and before any benefits will be paid:

1. A newly-enrolled and arriving student must have enrolled in full-time Studies at the higher education institution, and
2. All premiums must be paid.

Coverage under the Extended Coverage Benefit will become effective on the later of:

1. 30 days prior to the beginning of the term, or, if later,
2. On the first day the qualifying, newly-enrolled and arriving student arrives in the United States.

Students Concluding their Studies

A Plan Participant may extend coverage for a maximum of 30 days while remaining in the United States following graduation or completion of an educational program. To be eligible for the Extended Coverage benefit and before any benefits will be paid:

1. The Insurer must receive the request for Extended Coverage prior to the termination of the Plan Participant's coverage, and
2. All premiums must be paid.

Coverage under the Extended Coverage Benefit will terminate on the earlier of:

1. 30 days following the Plan Participant's graduation or completion of an educational program, or
2. The date of departure from the United States.

Extended Coverage for Short-Term Programs

In the event the Plan Participant's entire program of study is less than 60 days, the applicable Extended Coverage benefit will be limited to seven days. All other Extended Coverage benefit provisions will apply as indicated herein.

3.0 PREMIUM, CANCELLATION, AND POLICY PROVISIONS

3.1 Premium Payment

All Premiums are payable before coverage is provided, unless otherwise agreed upon. All coverage under this Policy is subject to the timely payment of Premium.

3.2 Late Payment Provision

A period of 31 days will be allowed for payment of any Premium due from the Participating Organization, after the initial Premium payment. The Insurer will suspend coverage during this 31-day period if Premium is not received. A notice of Premium delinquency will be sent. If Premium is received during the timeframe outlined in the notice of delinquency, coverage will resume without interruption in coverage. If the Premium due is not paid, Insurer will cancel the Policy issued to the Participating Organization as of the date through which Premiums are paid.

3.3 Cancellation

While the Insurer shall not cancel this Plan because of eligible claims made by a Plan Participant, it may at any time terminate a Plan Participant, or modify coverage to different terms, if the Plan Participant has at any time:

- Misled the Insurer by misstatement or concealment;
- Knowingly claimed benefits for any purpose other than are provided for under this Plan;
- Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to the Insurer's detriment;
- Failed to observe the terms and conditions of this Plan or failed to act with utmost good faith.

If the Plan Participant cancels this Plan of insurance, the Plan Participant must notify the Participating Organization within 31 days of receipt of the Summary of Benefits and Medical Identification Card. Such documents must be returned to the Participating Organization. The Participating Organization has the discretion to either approve or deny such request. If approved, the Participating Organization will notify the Insurer and if no claim for benefits has been made under this Plan, then the Insurer will provide a full refund of the Premium submitted by the Participating Organization on behalf of the Plan Participant.

If the Plan Participant cancels this Plan of insurance after the 31-day period, and provided no claim for benefits has been made, the Insurer will return a percentage of the Premium submitted on a pro-rata basis.

If a claim for benefits has been submitted, or there has been an incident that may lead to a claim, the Insurer will not refund any Premium.

3.4 Termination of the Participating Organization

The Policy issued to a Participating Organization will terminate on the earliest of ;

- The date the Participating Organization no longer meets the definition of a Participating Organization, or
- The end of the month for which the last premium payment is made by the Participating Organization for insurance coverage under this Plan.

Termination of coverage for a Participating Organization will be without prejudice to any claim incurred prior to termination.

3.5 Period of Insurance

The insurance coverage term for the Plan Participant begins on the Effective Date as shown on the Medical Identification Card and ends at midnight on the date shown, but no longer than 365 days later. The coverage is not subject to guaranteed issuance or renewal.

3.6 Duration of Coverage

Benefits are paid to the extent that a Plan Participant receives any of the treatments covered under the Schedule of Benefits following the Effective Date, including any additional waiting periods and up to the date such individual no longer meets the definition of Plan Participant, or their last date of coverage.

3.7 Compliance with the Plan Terms

The Insurer's liability will be conditional upon that Plan Participant complying with its terms and conditions.

3.8 Fraudulent/Unfounded Claims

If any claim is in any respect fraudulent or unfounded, all benefits paid and/or payable in relation to that claim shall be forfeited and, if appropriate, recoverable.

3.9 Waiver of Terms or Conditions

The waiver of a term or condition by the Insurer in relation to an individual case will not prevent the Insurer from relying on such term or condition thereafter.

3.10 Denial of Liability

Neither the Insurer nor the Policyholder is responsible for the quality of care received from any institution or individual. This insurance coverage does not give the Plan Participant any claim, right or cause of action against the Insurer or Policyholder based on an act of omission or commission of a Hospital, Physician or other Provider of care or service.

3.11 Extension of Benefits

If a Plan Participant is hospital confined on the termination date of coverage, benefits will continue to be paid until the earlier of: discharge from the hospital they are confined to, or until the Maximum Benefit has been paid, whichever occurs first. In no event will benefits continue beyond 30 days from the termination date of coverage.

4.0 PREFERRED PROVIDER NETWORK

The Insurer maintains a Preferred Provider Network both within and outside the United States.

- **United States only: In-Network Preferred Provider:** This tier consists of all Providers as well as other preferred Providers designated by the Insurer and listed on the website. In-Network Providers have agreed to accept a Preferred Allowance as payment in full. The Medical Identification Card contains the logo for the network. Present it to the Physician or Hospital.
- **Out-of-Network Provider:** Utilizing Providers that are Out-of-Network is a more costly financial option for the Plan Participant. The Insurer reimburses such Providers up to an Allowable Charge as determined by the Insurer. The Provider may bill the Plan Participant the difference between the amounts reimbursed by the Insurer and the Provider's billed charge. Additionally, the Plan Participant will pay a Coinsurance amount that is higher than if an In-Network Provider were used.
- **Out-of-Network Area:** When there are no network Providers located within a 30-mile radius of your local residence, charges from such Providers will be treated the same as a U.S. In-Network Preferred Provider.

The Insurer retains the right to limit or prohibit the use of Providers which significantly exceed Allowable Charges.

5.0 PRE-AUTHORIZATION REQUIREMENTS AND PROCEDURES

Pre-Authorization is a process by which a Plan Participant obtains approval for certain medical procedures or treatments prior to the commencement of the proposed medical treatment. This requires the submission of a completed Pre-Authorization Request form to GBG Assist a minimum of five business days prior to the scheduled procedure or treatment date.

The following services require Pre-Authorization:

- Any Hospitalization;
- Outpatient or Ambulatory Surgery;
- All Cancer Treatment (Including Chemotherapy and Radiation);
- Prescription medications in excess of $3,000 per refill; and
- Medical Evacuation/Repatriation and all other Non-Medical Expense Benefits;
- Any condition, which does not meet the above criteria, but are expected to accumulate over $10,000 of medical treatment per Period of Insurance.

Either you, your doctor, or your representative must call the number listed on the back of the Medical Identification Card to obtain Pre-Authorization and verification of Network utilization. Prior to the performance of services, a letter of authorization will be provided.

Medical Emergency Pre-Authorizations must be received no later than 48 hours after the admission or procedure. In instances of an emergency, you should go to the nearest Hospital or Provider for assistance even if that Hospital or Provider is not part of the Network.

Failure to obtain Pre-Authorization will result in a 30% reduction in payment of covered expenses. Any such penalty will apply to the entire episode of care and does not apply to the Out-of-Pocket Maximum. If treatment would not have been approved by the Pre-Authorization process, all related claims will be denied.
Pre-Authorization approval does not guarantee payment of a claim in full, as additional Copayments and Out-of-Pocket expenses may apply. Benefits payable under the Plan are still subject to eligibility at the time charges are actually incurred, and to all other terms, limitations, and exclusions of the Plan.

In the event of an emergency that requires **medical evacuation,** contact GBG Assist in advance in order to approve and arrange such emergency medical air transportation. GBG Assist, on behalf of the Insurer, retains the right to decide the medical facility to which the Plan Participant shall be transported. Approved medical evacuations will only be to the nearest medical facility capable of providing the necessary medical treatment. If the person chooses not to be treated at the facility and location arranged by GBG Assist, then transportation expenses shall be the responsibility of the Plan Participant. Failure to arrange transportation as indicated will result in non-payment of transportation costs.

DESCRIPTION OF BENEFITS

6.0 MEDICAL EXPENSE BENEFIT DESCRIPTIONS

THE FOLLOWING PROVIDES AN EXPLANATION OF THE BENEFITS OFFERED BY THE INSURER. PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR THE SPECIFIC BENEFITS COVERED UNDER THIS PLAN OF INSURANCE.

All benefits provided under this Policy for a covered Illness or Injury must be:

- Ordered or recommended by a Physician and under the scope of the Physician's licensing; and
- Medically necessary; and
- Delivered in an appropriate medical setting.

6.1 HOSPITALIZATION AND INPATIENT BENEFITS

6.1.a Accommodations

Benefits are provided for room and board, special diets, and general nursing care. All charges more than the allowable semi-private room rate are the responsibility of the Insured.

Benefits are also provided for treatment in the Intensive Care or Coronary Care Unit if it is the most appropriate place for the Insured to be treated, the care provided is an essential part of the Insureds treatment, and the care provided is routinely required by patients suffering from the same type of Illness or Injury or receiving the same type of treatment.

The Insurer will pay costs if:

- Treatment is Medically Necessary for the Plan Participant to be treated on an Inpatient or Daycare basis,
- The stay in the Hospital is for a medically appropriate period of time, and
- The treatment received is provided or managed by a Physician or specialist

Not Covered Under this Benefit

Inpatient hospital confinements primarily for purposes of receiving non-acute, long term custodial care, respite care, chronic maintenance care, or assistance with Activities of Daily Living (ADL), are not eligible expenses. Expense for items that are provided solely for personal comfort or convenience such as television, private rooms, housekeeping services, guest meals and accommodations, special diets, telephone charges, and take-home supplies are not covered.

6.1.b Medical Treatment, medicines, laboratory, diagnostic tests, and ancillary services

Benefits are provided for Medically Necessary diagnosis and treatment of the Illness or Injury for which a Plan Participant is hospitalized, the following services are also covered:

- Blood transfusions, blood plasma, blood plasma expanders, and all related testing, components, equipment and services,
- Laboratory testing,
- Durable medical equipment,
- Diagnostic X-ray examinations,
- Radiation therapy,
- Respiratory therapy, and
- Chemotherapy.

6.1.c Inpatient Consultation by a Physician or Specialist

Benefits are provided for the reimbursement of one Physician visit per day while the Plan Participant is a patient in a Hospital or approved Extended Care Facility. Visits that are part of normal preoperative and postoperative care are covered under the surgical fee and Insurer will not pay separate charges for such care. If Medically Necessary, the Insurer may elect to pay more than one visit of different Physicians on the same day if the Physicians are of different specialties. The Insurer will require submission of records and other documentation of the Medical Necessity for the intensive services.

6.2 OUTPATIENT BENEFITS

6.2.a Physician Visits

Benefits are provided for medical visits to a Physician, in the Physician's office, if Medically Necessary. Benefits are limited to one visit per day per Plan Participant. The Insurer may elect to pay more than one visit to different Physicians on the same day if the Physicians are of different specialties.

6.2.b Outpatient Diagnostic Testing

Benefits are provided for diagnostic testing including echocardiography, ultrasound, MRI, and other specialized testing, to diagnose an Illness or Injury.

6.2.c Therapeutic Services

Benefits are provided for Medically Necessary therapeutic services rendered to a Plan participant as an outpatient of a Hospital or Provider's office. Services must be pursuant to a Physician's written treatment Plan, which contains short and long term treatment goals and is provided to Insurer for review. The following services must either:

- Produce significant improvement in the Plan Participant's condition in a reasonable and predictable period of time; and
- Be of such a level of complexity and sophistication, and the condition of the patient must be such that the required therapy can safely and effectively be performed; or
- Be necessary to the establishment of an effective maintenance program.

6.3 SURGICAL BENEFITS

6.3.a Surgical Services

Benefits are provided for covered surgical services received in a Hospital or a Physician's office. . Surgical services include: use of operation room and recovery room, operative and cutting-procedures, treatment of fractures and dislocations, surgical dressings, and other Medically Necessary services.

6.3.b Anesthesia Services

Benefits are provided for the service of an anesthesiologist, other than the operating surgeon or assistant, who administers anesthesia for a covered surgical or obstetrical procedure.

6.3.c Reconstructive Surgery

Benefits are provided for reconstructive surgery as a result of an Accident or Illness will be covered as long as it is determined that it is Medically Necessary.

6.4 EMERGENCIES

6.4.a Emergency Room

Benefits are provided for a Medical Emergency when incurred in a Hospital's emergency room. The Insurer retains the right to deem a true Medical Emergency. Admission to the Hospital is not required for benefit consideration. Within the United States, use of the emergency room for non-emergency services may result in higher Out-of-Pocket costs to the Plan Participant.

6.4.b Emergency Ground Ambulance Services

Benefits are provided for Medically Necessary emergency ground ambulance transportation to the nearest Hospital able to provide the required level of care.

Not Covered Under this Benefit

The use of ambulance services for the convenience of the Plan Participant will not be considered a covered service.

6.4.c Emergency Dental

Benefits are provided for Emergency Dental treatment and restoration of sound natural teeth required as a result of an Accident. All treatment must begin within 72 hours of the Accident. Routine dental treatment is not covered under this benefit.

6.5 OTHER BENEFITS (INPATIENT/OUTPATIENT)

6.5.a Mental Health Benefits

Benefits are provided for both inpatient mental health treatment in a Hospital or approved facility and for outpatient mental health treatment. A Physician, licensed clinical psychologist, social worker, or licensed professional counselor must provide all mental health care services. Treatment must be provided for a psychiatric disease identified in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual or the International Classification of Diseases.

Covered Under this Benefit

Non-medical counseling services including but not limited to addictive behavior counseling, marriage and family counseling, educational counseling, aptitude testing, educational testing and services are not covered under this benefit.

6.5.b Preventive Care

Benefits are provided for routine physical examinations, immunizations for infectious diseases as recommended by the Center for Disease Control and preventive medical attention.

6.5.c Home Health Care including Nursing Services

Benefits are provided for Home Nursing and other Home Health Care services. Nursing care is defined as prescribed care that can only be provided by a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) which is Medically Necessary to treat identified medical conditions on a temporary, limited basis. These services need to meet specified medical criteria to be covered. Home nursing is provided immediately following treatment as an inpatient on Physician recommendation. Home nursing is not provided solely for the convenience of the family caregiver.

6.5.d Diabetic Medical Supplies

Benefits are provided for certain diabetic supplies including insulin pumps and associated supplies.

656.e HIV/AIDS

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.

6.5.f Durable Medical Equipment

Benefits are provided for items which are designed for and able to withstand repeated use by more than one person and customarily serve a medical purpose. Such equipment includes but is not limited to, wheelchairs, Hospital beds, respirators, and dialysis machines. Such Durable Medical Equipment (DME) must be:

- Prescribed by a Physician,
- Customarily and generally useful to a person only during an Illness or Injury,
- Equipment must be appropriate for use in the home and are not disposable, and
- Determined by the Insurer to be Medically Necessary and appropriate.

Allowable rental fee of the Durable Medical Equipment must not exceed the purchase price. Charges for repairs or replacement of artificial devices or other Durable Medical Equipment originally obtained under this Plan will be paid at 50% of the allowable reasonable and customary amount.

Not Covered Under this Benefit

Some items not covered under Durable Medical Equipment include but are not limited to the following:

- Comfort items such as telephone arms and over bed tables, or
- Items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers, or
- Miscellaneous items such as exercise equipment, heat lamps, heating pads, toilet seats, bathtub seats, or
- The customizing of any vehicle, bathroom facility, or residential facility.

High performance devices for sports or improvement of athletic performance, and power enhancement or power-controlled devices, nerve stimulators, and other such enhancements are not covered. Limbs and other devices intended to replace the functionality of the body part being replaced and the repair and replacement of such devices are not covered.

6.5.g Alcohol and Substance Abuse

Benefits are provided for inpatient and outpatient services including diagnosis, counseling, and other medical treatment 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 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 the Plan Participant needs to continue such treatment.

6.5.h Prescription Medications

Benefits are provided for medications which are prescribed by a Physician and which would not be available without such Prescription.

Not Covered Under this Benefit

Certain treatments and medications, such as vitamins, herbs, aspirin, cold remedies, medicines, experimental and/or investigational medications, or supplies, even when recommended by a Physician, do not qualify as Prescription Medications. Any medication that is not scientifically or medically recognized for a specific diagnosis or that is considered as off label use, experimental, or not generally accepted for use will not covered, even if a Physician prescribes it.

6.5.i Passive War and Terrorism

This Plan covers bodily Injury directly or indirectly caused by, or resulting from certain acts of War and Terrorism, provided the Plan Participant is not an active participant, or in training for in such activities. This benefit considers the following activities, excluding the use of nuclear, chemical, or biological weapons of mass destruction.

1. War, hostilities or warlike operations (whether war be declared or not),
2. Invasion,
3. Act of an enemy foreign to the nationality of the Plan Participant or the country in, or over, which the act occurs,
4. Civil war, Riot, Rebellion, Overthrow of the legally constituted government,
5. Military or usurped power,
6. Explosions of war weapons,
7. Murder or Assault subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the Plan Participant whether war be declared with that state or not,
8. Terrorist activity.

7.0 NON-MEDICAL EXPENSE BENEFITS

ALL NON-MEDICAL EXPENSE BENEFITS MUST BE ARRANGED THROUGH GBG ASSIST. FAILURE TO DO SO WILL RESULT IN NON-PAYMENT OF BENEFITS. PLEASE CONTACT GBG ASSIST IN ADVANCE IN ORDER TO FACILITATE ADMINISTRATION OF THESE BENEFITS.

7.1 Compassionate Care Visit

The Insurer will reimburse travel costs to repatriate the Plan Participant to their Home Country in the event there is a serious life-threatening Illness, Injury, or death of a spouse, domestic partner, parent, parent-in-law, child,

grandchild, brother, sister of fiancé. The family member must be a resident in the Home Country of the Plan Participant. Travel costs include economy round-trip airfare to the Home Country with a return to the Plan Participant's country of study. In all cases, the decision rest solely with the insurance company's medical representatives who will make the final and binding determination. In the event of death, a certificate of death must be provided.

7.2 Medical Evacuation/Repatriation

In the event of an Emergency that requires medical evacuation**,** contact GBG Assist in advance in order to approve and arrange such emergency medical air transportation. GBG Assist, on behalf of the Insurer, retains the right to decide the medical facility to which the Plan Participant shall be transported. Approved medical evacuations will only be to the nearest medical facility capable of providing the necessary medical treatment. If the Plan Participant chooses not to be treated at the facility and location arranged by GBG Assist, then transportation expenses shall be the responsibility of the Plan Participant. Failure to arrange transportation as indicated will result in non-payment of transportation costs. The cost of a person accompanying a Plan Participant is covered under this Policy, with expenses subject to pre-approval by GBG Assist.

***Sea and Offshore Evacuation*:** If a Plan Participant is Injured or becomes ill at sea (i.e cruises, yachting, etc.), the Insurer will not consider any benefit until the Plan Participant is on land. This means any costs involved from an evacuation from sea to land will not be considered under this Plan. Once on land, this Plan will cover medical costs and further evacuation, according to the insurance coverage and terms. If a Plan Participant is at sea, the Insurer would request the Plan Participants are evacuated by sea rescue to a country within their purchased Area of Coverage, where circumstances allow.

Medical Repatriation: If a Plan Participant can no longer meet the Eligibility requirements due to medical reasons, GBG Assist and the Insured's attending Physician will make the determination if Medical Repatriation to the Home Country is necessary. GBG Assist will coordinate return to the Home Country. If the Plan Participant refuses Repatriation, the Plan will be terminated for failure to meet Eligibility requirements.

7.3 Return of Mortal Remains

A benefit for either repatriation of mortal remains or local burial is included. This benefit excludes fees for return of personal effects, religious or secular memorial services, clergymen, flowers, music, announcements, guest expenses and similar personal burial preferences. The necessary clearances for the return of a Plan Participant's mortal remains by air transport to the Home Country will be coordinated by GBG Assist.

7.4 Passport Recovery

The Insurer will pay up to a maximum as defined in the Schedule of Benefits in respect of reasonable expenses necessarily incurred abroad in obtaining the replacement of an Insured Person's lost or stolen passport. Additional expenses for missing flight and extending accommodations are not covered by this benefit.

7.5 Lost Baggage

Benefits are provided for Accidental loss or theft to baggage, clothing, and personal effects owned by the Insured Person, subject to depreciation tables selected by the Insurer, up to the maximum benefit indicated in the Schedule of Benefits. This plan provides benefits secondary to the reimbursement of the Common Carrier. Claims must be filed with the Common Carrier first. See Definitions, Conditions, and Exclusions for more information.

Conditions:

1. The Insured Person must observe ordinary proper care in the supervision of the insured property and in all cases of loss;

2. Claims will be evaluated on an "indemnity basis" only – not "new for old". This means the market value of the article less deduction for age, wear, tear and depreciation, or the cost of repair; whichever is the lesser.
3. Claims will not be considered unless proof of ownership and evidence of value is provided;
4. Any amount paid for temporary loss of baggage will be deducted from the final claim settlement if baggage proves to be permanently lost;
5. Proof of a Missing Bag Report must be filed with the Common Carrier;
6. Any amount paid by a Common Carrier in settlement toward the loss will be deducted from the final claim;
7. The Insurer may request any information from the Plan Participant it deems necessary in the settlement of a claim. Failure to provide additional information will result in a denial of the claim;
8. In the event of a claim in respect of a pair or set of articles the Insurer shall only be liable in respect of the value of that part of the pair or set which is lost, stolen or damaged.

Not covered under this benefit:

1. Damage to baggage of any kind and or its contents;
2. Any loss or theft, or suspected theft not reported to the police within 24 hours of discovery and a written report obtained;
3. Any damage or loss or theft of property in transit, which has not been reported to the Common Carrier and written report obtained. In the case of an airline a property irregularity report will be required;
4. Loss or theft of any property left unattended in a public place;
5. Any theft from an unattended motor vehicle unless the property is in a locked/covered baggage area and there is evidence of forced entry which has been verified by a police report;
6. Loss, damage or theft of Valuables/Electronic Items and money packed in checked baggage or other receptacles while travelling;
7. Loss or damage caused by decay, wear and tear, moth, vermin or atmospheric conditions;
8. Deterioration or mechanical derangement of any kind;
9. Loss due to confiscation or detention by customs or other authority;
10. Damage to sports equipment while in use;
11. Losses of jewelry while swimming;
12. Breakage of or damage to fragile articles and any consequence thereof;
13. Any loss or theft of phones, smart phones, computer equipment including tablet personal computers;
14. Unset precious stones, contact or corneal lenses, spectacles or accessories;
15. Stamps, documents, deeds, manuscripts or securities of any kind;
16. Items of a perishable nature;
17. Business goods, samples, tools of trade or motor accessories;
18. Household goods and home contents.

8.0 ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

The Plan Participant must receive initial medical treatment within 30 days of the date of Accident. The maximum amount payable for this benefit is the Principal Sum indicated on the Schedule of Benefits. If the Plan Participant incurs a covered loss, the Insurer will pay the percentage of the Principal Sum shown in the table on the Schedule of Benefits. If the Plan Participant sustains more than one such loss as the result of one Accident, the Insurer will only pay one amount, the largest to what the Plan Participant is entitled. Except for Accidental Death, the loss must result within 90 days of the Accident. Your coverage under the Plan must be inforce.

For purposes of this benefit:

- Loss of a Hand or Foot means complete severance through or above the wrist or ankle joint.

- Loss of Use of a Hand or Foot means total loss of all ability to move the hand or foot, within 365 days of a Covered Accident, that continues for 6 months and is expected to continue for the remainder of the Plan Participant's lifetime.
- Loss of Sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.
- Severance means the complete separation and dismemberment of the part from the body.

9.0 EXCLUSIONS AND LIMITATIONS

9.1 Medical Expense Benefits Exclusions and Limitations

All services and benefits described below, including expenses for medical treatment not expressly indicated in the Medical Expense Benefit section, are either excluded from coverage or limited under this Plan of Insurance.

1. **Abortion:** Any voluntarily induced termination of pregnancy and complications thereof, except if the mother's life is in danger.
2. **Aircraft Travel:** Travel in any aircraft owned, leased operated or controlled by the Policyholder, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by the Policyholder if the aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year.
3. **Alcohol and Substance Abuse, Secondary Illness/Injury:** Treatment of any Illness or Injury caused by, contributed to, or resulting from voluntary use of alcohol, illegal substance abuse, drug, poison, gas or fume, or any medication that is not taken in the dosage or for the purpose prescribed. The operating of any type of vehicle or conveyance while under the influence of alcohol or any of the above listed substances including prescribed drugs for which the Insured was provided a written warning against operating a vehicle or conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the state in which the Covered Loss occurred.
4. **Breast reduction**: All services and treatments.
5. **Charges Reimbursable by Another Entity:** Services, supplies, or treatment that are provided by or payment is available from: a) Workers' Compensation law, occupational disease law or similar law concerning job related conditions of any country; or; b) Another insurance company or government; or c) A government entity due to an epidemic or public emergency; d) Services provided normally without charge by the Health Services Center of the institution attended by the Plan Participant, or services covered or provided by a student health fee.
6. **Cosmetic and Elective Surgery for Non-Medical Reasons:** Treatments, procedures or medications which are primarily for enhancement, improvement, or altering one's appearance, unless required due to a non-occupational Injury occurring while insured under this Plan. Medical complications arising from such treatments or procedures are also not covered.
7. **Dental Care:** Except for Accidental injury to sound, natural teeth.
8. **Experimental or Off-Label Services:** Services, supplies or treatments, including medications, which are deemed to be Experimental or Investigational or that is not medically recognized for a specific diagnosis.
9. **Fertility/Infertility Treatments and Birth Control:** Any services, procedure or treatment including medications used to: a) Treat infertility including In-vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), and any variations of these procedures, and any costs associated with the preparation or storage of sperm for artificial insemination. b) Vasectomies and sterilization, and any expenses for male or female reversal of sterilization. c) Contraceptive devices including the insertion or removal of such devices, including oral contraceptives.
10. **Genetic Screening:** Counseling, screening, testing, or treatment in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
11. **Hearing Care:** Hearing exams, hearing aids or devices, unless due to an Injury/Illness covered under the Policy. Surgical implantation of, or removal of bone anchored hearing devices and cochlear implants.

12. **Home Country:** All medical charges incurred in the Plan Participant's Home Country, in excess of the amount shown on the Schedule of Benefits.
13. **Illegal Activities:** Injuries or Illnesses resulting or arising from or occurring during the commission of an assault or felony.
14. **Immunizations for Travel:** Vaccines and preventive medications recommended or required for travel to specific countries.
15. **Maternity:** Pregnancy or childbirth, miscarriage resulting from an accident, elective abortion; elective cesarean section; or any complications of any of these conditions; pregnancy or childbirth of a Dependent when Dependent Child of an Insured Person.
16. **Medical Examinations or Certificates:** Any examination, immunization, or tests necessary for the issuance of medical certificates or determining employment, or suitability for school, sport related activities, or travel or determining insurability.
17. **Motor Vehicle:** Medical expenses resulting from a motor vehicle Accident if the Plan Participant is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Plan Participant holds a valid learners permit and (b) the Plan Participant is receiving instruction from a driver's education instructor.
18. **Nasal Surgery:** Deviated septum, submucous resection and/or other surgical correction thereof, nasal and sinus surgery except for treatment of a covered Injury.
19. **Non-Medical Care:** Services related to Custodial Care, respite care, home-like care, assistance with Activities of Daily Living (ADL), or Milieu Therapy. Any Admission to a nursing home, home for the aged, long term care facility, sanitarium, spa, hydro clinic, or similar facilities. Any Admission arranged wholly or partly for domestic reasons, where the Hospital effectively becomes or could be treated as the Plan Participant's home or permanent abode.
20. **Organ Transplant:** Organ transplant and related procedures and expenses.
21. **Podiatric Care:** Routine foot care, including the paring and removing of corns, calluses, or other lesions, or trimming of nails or other such services not resulting from an Illness or Injury. Orthopedic shoes or other supportive devices such as; arch supports, orthotic devices, or any other preventative services or supplies to treat the diagnosis of weak, strained, or flat feet or fallen arches.
22. **Prescription Medications:** Prescription Medications, services or supplies as follows:
    a) Therapeutic devices or appliances, including: support garments and other non-medical substances, regardless of intended use, except as specifically provided in this Plan, b) Immunization agents, except as specially provided, biological sera, blood or blood products administered on an Outpatient basis, c) Refills in excess of the number specified or dispensed after one year of the date of the prescription, d) Growth hormones, e) Medications used to treat or cure baldness or thinning hair.
23. **Sexual Dysfunction:** Any procedures, supplies, or medications used to treat male or female sexual enhancement or sexual dysfunction such as erectile dysfunction, premature ejaculation, and other similar conditions.
24. **Skin Conditions:** Acne, rosacea, skin tags, and any other treatment to enhance the appearance of the skin, except for cystic or pustular acne.
25. **Sleep Studies:** Sleep studies and other treatments relating to sleep apnea.
26. **Smoking Cessation:** Treatments and other expenses, whether or not recommended by a Physician.
27. **Sports and Hazardous Activities:** a) Participation, practice, or conditioning program for any Intercollegiate or professional sport or competition, including cheerleading, or travelling to/from such sport or competition as a participant; b) Skydiving, parachuting, SCUBA diving (deeper than 30 meters), mountain climbing (where ropes or guides are used), bungee jumping, skiing (off groomed trails), snowboarding, racing by any animal or motor vehicle, motorcycling, spelunking, whitewater rafting (level 4 and higher), hang gliding, glider flying, parasailing, or flight in any kind of aircraft (except as a passenger in a regularly scheduled flight of a commercial airline); c) Power Vehicles: Expenses for Accidents or Injuries as a result of motorcycles, mopeds, scooters, ATV's, any one, two, or three wheeled motorized vehicle and/or sport watercraft such as wave runners, jet skis, or other powered devices whether the vehicle is in motion or not.;

28. **Transsexual Surgery:** Medical or psychological counseling, hormonal therapy in preparation for, or subsequent to, any such surgery, surgical procedures, and any other expenses related to sexual reassignment including the complications arising from such procedures.
29. **Vision Care:** Expenses including examinations, eye refractions, frames, lenses, contact lenses, fitting of frames or lenses, or vision correction surgery.
30. **War and Terrorism:** a) Any loss sustained while participating in, or training for, or as a consequence of war (declared or not), or warlike operations; b) voluntary, active participation in a riot or insurrection; c) Terrorist activity including the use of armaments, the detonation of any form of explosive or nuclear devices, the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent, including the poisoning via the air or water supplies or food products and deliberate destruction of buildings and transportation. This exclusion extends to any action taken in controlling, preventing, suppressing or in any way relating to any terrorist activity; d) Ionizing radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel, or the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
31. **Weight Related Treatment:** Any expense, service, or treatment for obesity, weight control, any form of food supplement, weight reduction programs, dietary counseling, or surgical procedures related to morbid or non-morbid obesity. Charges relating to complications arising from such treatments or surgical procedures are also excluded.
32. Services or treatment rendered by any person who is: a) living in the Plan Participant's household, b) an Immediate Family Member of either the Plan Participant or the Plan Participant's spouse, or c) the Plan Participant.

9.2 Non-Medical Expense Benefits Exclusions and Limitations

The Insurer shall not be responsible for providing the following non-medical expense benefits to a Plan Participant in a situation arising from or in connection with any of the following.

1. Travel costs that were neither arranged or approved in advance by the Insurer or authorized vendor or affiliate.
2. Taking part in military or police operations.
3. Plan Participant's failure to properly procure or maintain visa, permits, or other documents.
4. The actual or threatened use or release of any nuclear, chemical, or biological weapon or device, or exposure to nuclear reaction or radiation, regardless of the contributory cause.
5. Any evacuation or repatriation that requires a Plan Participant to be transported in a biohazard-isolation unit.
6. Medical evacuation from a marine vessel, ship, or watercraft of any kind.
7. Medical evacuation directly or indirectly related to a natural disaster.
8. Subsequent medical evacuations for the same or related Illness, Injury, or emergency medical evacuation event regardless of location.

9.3 Accidental Death & Dismemberment Exclusions and Limitations

The losses shown below or expenses resulting from or in connection with any of the following are excluded from coverage under this Policy.

Illegal Activities: Losses resulting or arising from or occurring during the commission of an assault or felony.

Kidnap and Hijacking: Any loss caused directly or indirectly from kidnap or wrongful detention of the Insured or hijacking of any aircraft, motor vehicle, train or waterborne vessel on which the Plan Participant is travelling.

Professional Sports: Any loss sustained while participating in or training for any sport or activity performed for financial gain.

Self-Inflicted Illnesses, Injuries, or Exceptional Danger: a) Treatment for any conditions as a result of self-inflicted Illnesses or injuries, suicide or attempted suicide, while sane or insane. b)Treatment for any loss or expense of nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with self-exposure to peril or bodily Injury, except in an endeavor to save human life.

Sports and Hazardous Activities: a) Participation, practice, or conditioning program for any Intercollegiate or professional sport or competition, including cheerleading, or travelling to/from such sport or competition as a participant; b) Skydiving, parachuting, SCUBA diving (deeper than 30 meters), mountain climbing (where ropes or guides are used), bungee jumping, skiing (off groomed trails), snowboarding, racing by any animal or motor vehicle, motorcycling, spelunking, whitewater rafting (level 4 and higher), hang gliding, glider flying, parasailing, or flight in any kind of aircraft (except as a passenger in a regularly scheduled flight of a commercial airline); c) Power Vehicles: Expenses for Accidents or Injuries as a result of motorcycles, mopeds, scooters, ATV's, any one, two, or three wheeled motorized vehicle and/or sport watercraft such as wave runners, jet skis, or other powered devices whether the vehicle is in motion or not.;

Substance Abuse: Any loss directly or indirectly resulting from alcohol or illegal drug abuse or other addiction, or any drugs or medicines that are not taken in the dosage or for the purpose prescribed.

War and Terrorism: a) Any loss sustained while participating in, or training for, or as a consequence of war (declared or not), or warlike operations. b) voluntary, active participation in a riot or insurrection c) Terrorist activity including the use of armaments, the detonation of any form of explosive or nuclear devices, the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent, including the poisoning via the air or water supplies or food products and deliberate destruction of buildings and transportation. This exclusion extends to any action taken in controlling, preventing, suppressing or in any way relating to any terrorist activity. d) Ionizing radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel, or the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

10.0 HOW TO FILE A CLAIM

Claims must be filed within **180 days** of treatment to be eligible for reimbursement of covered expenses. Claim forms should be submitted only when the medical service Provider does not bill the Insurer directly, and when you have out-of-pocket expenses to submit for reimbursement. All claims worldwide are subject to Usual, Customary, and Reasonable charges as determined by GBG and are processed in the order in which they are received. In order for claims payment to be made, claims must be submitted in a form acceptable to Insurer.

10.1 Medical and Prescription Medication Claims

To file your claim, submit it online at www.gbg.com. Log into the Member Area and select Submit Claim, and then follow the instructions to complete the online claim form. If you are unable to submit your claim electronically, you can mail or fax your completed claim form and copies of supporting documentation. After submitting the claim, you will receive a claim reference number and an electronic receipt for the claim will be sent to you by email.

Claims may be submitted to the Insurer directly by the Provider or Facility. The Insurer will process the claim according to the Schedule of Benefits and Plan terms, and remit payment to the health care Provider. Ineligible charges or those in excess of the Allowable Charges will be the responsibility of the Plan Participant.

If the Plan Participant has paid the health care Provider, the Plan Participant will submit the claim form along with the original paid receipts directly to the Insurer. Photocopies will not be accepted unless the Claim is submitted electronically. The Insurer will reimburse the Plan Participant directly according to the Schedule of Benefits and Plan terms.

10.2 Accidental Death and Dismemberment Claims

To substantiate a claim for benefits covered by the terms of this Plan, the following initial documents must be submitted:

- An official certificate of death, indicating date of birth of the Plan Participant;
- A detailed medical report at the onset and course of the disease, bodily Injury or Accident that resulted in the death or dismemberment. In the event of no medical treatment, a medical or official certificate stating the cause and circumstances of death;
- The Insurer will pay the benefit as soon as the validity of the claim for benefits has been reasonably satisfied. Expenses incurred in relation to the substantiation of a claim will not be the responsibility of the Insurer.

Submit claims by:

Web:	**Mail:**	**Fax:**	**Email:**
www.gbg.com	GBG Administrative Services 7600 Corporate Center Drive, Suite 500 Miami, FL 33126 USA	+1 949 271 2330	eclaims@gbg.com

10.3 Reimbursement Options

Claims reimbursements will be made by:

- Electronic Direct Deposit for the Plan Participant where the receiving bank is located in the U.S.,
- Wire Transfer for the Plan participant's and overseas Providers where the receiving bank is located outside of the U.S., or
- Check sent to the Plan participant or Provider where electronic payment is not possible.

10.4 Settlement of Claims

When claims are presented to the Insurer, the Allowable Charges will be applied towards the Deductible. Once the Deductible has been satisfied, all Allowable Charges will be paid at the percentage listed on the Schedule of Benefits, up to the listed benefit maximum. Note the amount of Allowable Charges applied towards the Deductible also reduces the applicable benefit maximum by the same amount.

If the Plan has an Out-of-Pocket Maximum, once it is met the Plan will begin paying 100% of Allowable Charges for the remainder of insurance coverage, subject to the benefit maximums. The Out-of-Pocket Maximum does not apply to any expenses covered under the Prescription Medications benefit.

10.5 Status of Claims

Plan Participant's wishing to request the status of a claim or have a question about a reimbursement received, please submit the status request form via our website at www.gbg.com or e-mail customer service at customerservice@gbg.com. Inquiries regarding the status of past claims must be received within 12 months of the date of service to be considered for review.

10.6 Releasing Necessary Information

It may be necessary for the Insurer to request a complete medical file on a Plan Participant for purpose of claims review or administration of the Plan. It may also be necessary to share such information with a medical or utilization review board, or a reinsurer. The release of such confidential medial information will only be with written consent of the Plan Participant.

10.7 Coordination of Benefits

It is the duty of the Plan Participant to inform Insurer of all other coverage. In no event will more than 100% of the Allowable Charge and/or maximum benefit for the covered services be paid or reimbursed. If a Plan Participant has coverage under another insurance contract, including but not limited to health insurance, worker's compensation insurance, automobile insurance (whether direct or third party), occupational disease coverage, and a service received is covered by such contracts, benefits will be reduced under this Plan to avoid duplication of benefits available under the other contract. This includes benefits that would have been payable had the Plan Participant claimed for them.

10.8 Subrogation

When the Plan pays for expenses that were either the result of the alleged negligence, or which arise out of any claim or cause of action which may accrue against any third party responsible for Injury or death to the Plan Participant by reason of their eligibility for benefits under the Plan, the Plan has a right to equitable restitution.

11.0 COMPLAINTS PROCEDURE

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 complaint 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	+1.786.814.4125	complaints@gbg.com

(within the U.S. and Canada) (outside the U.S. and Canada)

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

12.0 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:
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;

- 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;
- Monitoring and/or recording of Your telephone calls in relation to coverage for the purposes of record-keeping, training and quality control;
- 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;
- 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
- 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/" \l "/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/" \l "/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

13.0 DEFINITIONS

Certain words and phrases used in this Plan are defined below. Other words and phrases may be defined where they are used.

Accident: Any sudden and unforeseen event occurring during the insurance coverage year period, resulting in bodily Injury, the cause or one of the causes of which is external to the Plan Participant's own body and occurs beyond the Plan Participant's control.

Activities of Daily Living (ADL): Activities of daily living are those activities normally associated with the day-to-day fundamentals of personal self-care, including but not limited to: walking, personal hygiene, sleeping, toilet/continence, dressing, cooking/feeding, medication, and getting in and out of bed.

Acute Care: Medically Necessary, short-term care for an Illness or Injury, characterized by rapid onset, severe symptoms, and brief duration, including any intense symptoms, such as severe pain.

Admission: The period from the time that a Plan Participant's enters a Hospital, Extended Care Facility or other approved health care facility as an inpatient until discharge.

Air Ambulance: An aircraft specially equipped with the necessary medical personnel, supplies and Hospital equipment to treat life-threatening Illnesses and/or Injuries for Plan Participant's whose conditions cannot be treated locally and must be transported by air to the nearest medical center that can adequately treat their conditions. This service requires Pre-Authorization. A commercial passenger airplane does not qualify as an air ambulance.

Allowable Charge: The fee or price the Insurer determines to be the Usual, Customary and Reasonable Charges for health care services provided to Plan Participants. The Plan Participant is responsible for the payment of any balance over the Allowable Charge (except in the U.S. when a Preferred Provider has delivered the service). P All services must be Medically Necessary. Once an Allowable Charge is established then the Deductible, Coinsurance, Copayments and any excess charges must be paid by the Plan Participant.

Ambulatory Surgical Center: A facility which (a) has as its primary purpose to provide elective surgical care; and (b) admits and discharges a patient within the same working day; and (c) is not part of a Hospital. Ambulatory Surgical Center: does not include: (1) any facility whose primary purpose is the termination of pregnancy; (2) an office maintained by a Physician for the practice of medicine; or (3) an office maintained by a Dentist for the practice of Dentistry.

Club Sports: Any sports offered at a university or college in the United States that compete with other universities, or colleges, but are not regulated by the National Collegiate Athletic Association (NCAA) or National Association of Intercollegiate Athletics (NAIA), and do not have varsity status.

Coinsurance: The percentage amount of the Allowable Charges that the Plan Participant and the Insurer will share after the Deductible and Copayment is met.

Common Carrier: An individual, a company, or public utility which is in the regular business of transporting people and for which a fair has been paid.

Complications of Pregnancy: A condition;

- Caused by pregnancy; and
- Requiring medical treatment prior to, or subsequent to termination of pregnancy; and
- The diagnosis of which is distinct for pregnancy; and
- Which constitutes a classifiably distinct complication of pregnancy.

A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

Confinement: Inpatient stay at an approved extended care facility for necessary skilled treatment or rehabilitation in accordance with the contract.

Congenital Condition: Any heredity condition, birth defect, physical anomaly and/or any other deviation from normal development present at birth, which may or may not be apparent at that time. These deviations, either physical or mental, include but are not limited to, genetic and non-genetic factors or inborn errors of metabolism.

Copayment: A fixed dollar amount that may be applied per office visit each time medical services are received. Ancillary services such as Laboratory and Radiology service (i.e. blood tests, x-rays) that may be in conjunction with an office visit do not require a separate Copayment. Copayments do not apply to the Deductible or to the Out-Of-Pocket Maximum.

Cosmetic Surgery: Surgery or therapy performed to improve or alter appearance for self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.

Covered Expense: Charges that are Medically Necessary and that are:

1. Not in excess of the maximum amount payable for services as specified in the Schedule of Benefits;
2. In excess of any Deductible amount; and
3. Incurred while the Plan Participant's coverage under this Policy is in force.

Creditable Coverage: Insurance coverage of an individual under any of the following:

1. A group health plan.
2. Individual or group health coverage.
3. Medicare.
4. Medicaid.
5. Medical and dental care for members and certain former members of the uniformed services and for their dependents.
6. A medical program of the federal Indian health service or tribal organization.
7. A state health benefits risk pool.
8. The Federal Employees Health Benefits Program.
9. The State Children's Health Insurance Program (S-CHIP).
10. Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
11. Any public health benefit program provided by state, country, or other political subdivision of a state.
12. A health benefit plan under the federal Peace Corps Act.

Custodial Care: Includes: (1) the provision of room and board, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, as determined by the individual's attending Physician, has reached the maximum level of recovery; and (2) in the case of an institutionalized person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be

expected that medical or surgical treatment will enable him to live outside an institution; and (3) rest cures, respite care and home care provided by family Insureds. Upon receipt and review of a claim, the Insurer or an independent medical review will determine if a service or treatment is Custodial Care.

Deductible: The amounts of covered Allowable Charges payable by the Plan Participant during each Period of Insurance before the Plan benefits are applied. Such amount will not be reimbursed under the Plan. The Deductible is not considered part of the Out-Of-Pocket Maximum.

Dependent: Refers to a member of the Plan Participant's family who is enrolled under the Plan with the Insurer after meeting all the eligibility requirements and for whom premiums have been received.

Durable Medical Equipment: Orthopedic braces, artificial devices replacing body parts and other equipment customarily and generally useful to a person only during an Illness or Injury and determined by Insurer on a case by case basis to be Medically Necessary including motorized wheelchairs and beds. See DME Section for more details and services that are not consider eligible benefits.

Effective Date: The date upon which the Plan Participant's coverage will commence under this Plan.

Eligibility: The requirements that a Plan Participant, including the primary Plan Participant and dependents must meet at all times in order to be covered under this Plan.

Emergency Dental Treatment: Emergency dental treatment is urgent treatment necessary to restore or replace sound natural teeth damaged as a result of an Accident. Sound teeth do not include teeth with previous crowns, fillings, or cracks. Damage to teeth caused by chewing foods does not qualify for emergency dental coverage.

Experimental and/or Investigational: Any treatment, procedure, technology, facility, equipment, medication, medication usage, device, or supplies not recognized as accepted medical practice by Insurer.

Extended Care Facility: A nursing and/or rehabilitation center approved by Insurer that provides skilled and rehabilitation services to patients who are discharged from a Hospital or who are admitted in lieu of a Hospital stay. The term Extended Care Facility does not include nursing homes, rest home, health resorts, homes for the aged, infirmaries or establishments for domiciliary care, custodial care, care of substance abuse addicts or alcoholics, or similar institutions.

HIV: Acquired Immune Deficiency Syndrome (AIDS) and all diseases caused by and/or related to the HIV Virus.

Home Country:
The country from which the Plan Participant holds a passport. If the Plan Participant holds passports from more than one country, the Home Country will be the country declared to in writing as their Home Country.

Home Health Care Agency: An agency or organization, or subdivision thereof, that; a) is primarily engaged in providing skilled nursing services and other therapeutic services in the Plan Participant's home; b) is duly licensed, if required, by the appropriate licensing facility; c) has policies established by a professional group associated with the agency or organization, including at least one Physician and one registered graduate nurse (R.N.), to govern the services provided; d) provides for full-time supervision of such services by a Physician or by a Registered Nurse (R.N.), e) maintains a complete medical record on each patient; and f) has a full-time administrator.

Home Health Care Plan: A program: 1) for the care and treatment of a Plan Participant in his home; 2) established and approved in writing by his attending Physician; and 3) Certified, by the attending Physician, as

required for the proper treatment of the Injury or Illness, in place of inpatient treatment in a Hospital or in an Extended care Facility.

Hospice: An agency which provides a coordinated Plan of home and inpatient care to a terminally ill person and which meets all of the following tests: 1) has obtained any required state or governmental license or Certificate of Need; 2) provides service 24-hours-a-day, 7 days a week; 3) is under the direct supervision of a Physician; 4) has a nurse coordinator who is a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.); 5) has a duly licensed social service coordinator; 6) has as its primary purpose the provision of Hospice services; 7) has a full-time administrator; and 8) maintains written records of services provided to the patient.

Hospital: Includes only acute care facilities licensed or approved by the appropriate regulatory agency as a hospital, and whose services are under the supervision of, or rendered by a staff of Physicians who are duly licensed to practice medicine, and which continuously provides twenty-four (24) hour a day nursing service under the direction or supervision of registered professional nurses. The term Hospital does not include nursing homes, rest home, health resorts, and homes for the aged, infirmaries or establishments for domiciliary care, custodial care, care of substance abuse addicts or alcoholics, or similar institutions.

Illness: A disease, sickness, or infection, other than those related to psychiatric illness or mental stress.

Injury: Bodily harm caused by an Accident. The Accident must occur while the Plan Participant's insurance is in force under this Plan. All Injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single covered Injury. The Injury must be the direct cause of an Accident covered under this Plan and must be independent of all other causes. The Injury must not be caused by or contributed to by Illness.

Inpatient: A Plan Participant admitted to an approved Hospital or other health care facility for a Medically Necessary overnight stay.

Intercollegiate Sport: A sport that:
1. has been accorded varsity status by the participating School;
2. is administered by such School's department of intercollegiate athletics for which the eligibility of the participating student athlete is reviewed and certified in accordance with the applicable intercollegiate sports organization's legislation, rules or regulations;
3. entitles qualified participants to receive the participating School's official awards;
4. includes travel, only within the contiguous United States, including Alaska and Hawaii and only directly and without interruption between home, School and the premises of the Intercollegiate Sporting event

Interscholastic Sport: A sport played between secondary schools.

Intramural Sport: a sport that:
1. is approved by the sports director or athletic director of the School; and
2. involves only students at the same School; and
3. takes place within the walls, boundaries and grounds of said School;

Lifetime Maximum: Payment of benefits is subject to a lifetime aggregate maximum per individual Plan Participant as indicated in the Schedule of Benefits, as long as the Plan remains in force. The Lifetime Maximum includes all benefit maximums specified in the Plan, including those specified in the Schedule of Benefits.

Lookback Period: The amount of time that will be reviewed to determine if a claim is related to a Pre-Existing condition.

Master Policy: The agreement between the Insurer and the Multi-National Benefit Trust.

Maximum Benefit: The payment specified in the Schedule of Benefits, for specific services, which is the maximum amount payable by Insurer per person, regardless of the actual or allowable charge. This is after the Plan Participant has met his obligations of Deductible, Coinsurance, Copayments and any other applicable costs.

Medical Emergency: A sudden, unexpected, and unforeseen event caused by an Illness or Injury that manifests itself by symptoms of sufficient severity that a prudent layperson would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

Medical Identification Card: The card provided to each Plan Participant. This card contains limited benefit information including the Effective Date of coverage, as well as contact information for submitting claims and emergency medical treatment.

Medically Necessary: Means that a service or supply is necessary and appropriate for the diagnosis or treatment of an Illness or Injury based on generally accepted current medical practice. A service or supply will not be considered as Medically Necessary if:

1. it is provided only as a convenience to the Plan Participant or Provider;
2. it is not the appropriate treatment for the Plan Participant's diagnosis or symptoms;
3. it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

The fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Nurse: A licensed graduate registered nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not:

1. the Plan Participant;
2. an Immediate Family Member of either the Plan Participant or the Plan Participant's spouse; or
3. a Member of the same household

Outpatient: Services, supplies or equipment received while not an inpatient in a hospital, or other health care facility, or overnight stay.

Out-of-Network Provider: Any Hospital, Physician, or other provider of health care services who has not agreed to any pre-arranged fee schedules.

Out-of-Pocket Maximum: The maximum dollar amount of expenses the Plan Participant will pay for Allowable Charges during the Plan year after the Deductible is met. Once the Plan year Coinsurance maximum is reached, the Insurer shall pay most benefits at 100% of eligible covered expenses for the remainder of the Plan year.

Participating Organization: An organization which elects to offer insurance coverage, completes an application, and has been approved by the Insurer to sponsor coverage under this Plan.

Period of Insurance: The start and end date for which insurance coverage is in effect as shown on the Medical Identification Card. When multiple Certificates are issued during a School Year, the Maximum Benefit is an accumulation of all Certificates issued during the School Year.

Physician: A licensed health care provider and/or licensed therapist practicing within the scope of their license and rendering care and treatment to the Plan Participant that is appropriate for the condition and locality, and who is not:

1. the Plan Participant;
2. an Immediate Family Member of either the Plan Particiapnt or the Plan Participant's Spouse;
3. a person living in the Plan Participant's household; member of the same household;
4. a person employed or retained by the Policyholder; or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

Plan: The agreement between the Insurer and the Policyholder. The Plan includes the Master Policy, the Summary of Benefits, the Schedule of Benefits, and the application.

Plan Participant: A person eligible for coverage as identified in the application form, a Non-United States Citizen traveling outside their Home Country and has his true, fixed and permanent home and principal establishment outside of the United States and holds a current and valid passport, and for whom proper Premium payment has been made when due.

Pre-Authorization: A process by which a Plan Participant obtains written approval for certain medical procedures or treatments from the Insurer prior to the commencement of the proposed medical treatment. Certain medical procedures will require the Pre-Authorization process to be followed in order for the service to be covered and to maximize the benefits of the Plan Participant.

Pre-Existing Condition: A pre-existing condition is a disease or physical condition for which medical advice or treatment has been received within 12 months immediately prior to becoming covered under the Plan.

Preferred Allowance: Refers to the amount an In-Network Provider will accept as payment in full for covered medical expenses.

Preferred Provider: Refers to the providers and hospitals who have contracted with a Preferred Provider Organization to provide specific medical care at negotiated prices.

Preferred Provider Organization (PPO): Refers to a participating Provider, such as Hospital, clinic or Physician that has entered into an agreement to provide health services to Plan Participants.

Premium(s): The consideration owed by the Plan Participant to the Insurer in order to secure benefits for its Plan Participant's under this Plan.

Prescription Medications: Prescription medications are medications which are prescribed by a Physician and which would not be available without such prescription. Certain treatments and medications, such as vitamins, herbs, aspirin, cold remedies, medicines, experimental or Investigative medications, or medical supplies even when recommended by a Physician, do not qualify as prescription medications.

Professional Sports: Activities in which the participants receive payment for participation. This does not include participants in National Collegiate Athletic Association (NCAA) or National Association of Intercollegiate Athletics (NAIA).

Provider: The organization or person performing or supplying treatment, services, supplies or medications.

Rehabilitation: Therapeutic services designed to improve a patient's medical condition within a predetermined time period through establishing a maintenance program designed to maintain the patient's current condition, prevent it from deteriorating and assist in recovery.

Rehabilitation Facility: A legally operating institution or part of an institution which has a transfer agreement with one or more Hospitals and which:

1. is primarily engaged in providing comprehensive multi-disciplinary physical rehabilitative services or rehabilitation inpatient care; and
2. is duly licensed by the appropriate government agency to provide such services; and
3. is required to be accredited by the Joint Commission on Accreditation of Health Care Organizations or the Commission on Accreditation of Rehabilitation Facilities.

A Rehabilitation Facility does not include institutions which provide only minimal care, custodial care, care for the terminally ill, part-time care, or services or facilities for drug abuse or alcoholism.

Repatriation or Local Burial: This is the expense of preparation and the air transportation of the mortal remains of the Plan Participant from the place of death to their Home Country, or the preparation and local burial of the mortal remains of a Plan Participant who dies outside their Home Country. This benefit is excluded where death occurs in their Home Country.

Schedule of Benefits: The summary description of the benefits, payment levels and maximum benefits, provided under this Plan.

School Year: The 12-month period when the educational institution begins classes, usually starting in late summer and may conduct classes on a quarterly, semester, or other regularly scheduled basis.

Skilled Nursing: Refers to a patient's need for care or treatment that can only be performed by licensed nurses. Examples of Skilled Nursing includes complex wound dressings, rehabilitation, tube feedings, or a rapidly changing health status.

Skilled Nursing Facility: means an institution which meets all the following requirements;

1. it must be operated pursuant to law;
2. it must be primarily engaged in providing, in addition to room and board accommodations, nursing services under a licensed Physician's supervision;
3. Registered or License Practical Nurses must supervise 24 hours a day; and
4. a daily record for each patient must be maintained.

This definition does not include:

1. Rest home or similar facility;
2. Home or facility for the aged;
3. Home or facility for drug addicts and alcoholics;
4. Home or facility for care and treatment of mental diseases and disorders; or
5. Home or facility for custodial or educational care.

Spouse: The Plan Participant's lawful spouse, civil partner, or domestic partner.

Student Health Center: A facility that meets all of the following requirements: 1) located in or near a School facility and open during School hours; 2) organized through the School, community, and health Provider relationships: and 3) staffed by qualified health care Providers.

Subrogation: Circumstances under which the Insurer may recover expenses for a claim paid out when another party should have been responsible for paying all, or a portion of that claim.

Summary of Benefits: The document provided to the Plan Participant that includes the Schedule of Benefits and the terms of the Master Policy issued to the Trust.

Terrorism: Terrorist activity means an act, or acts, of any person, or groups of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist activity can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of terrorist activity can either be acting alone, or on behalf of, or in connection with any organization or government.

Usual, Customary and Reasonable Charge (UCR): Fees and prices generally reimbursed within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

Waiting Period: The period of time beginning with the Plan Participant's Effective Date, during which limited, or no benefits are available for particular services. After satisfaction of the Waiting Period, benefits for those services become available in accordance with this Plan.

We, Us, Our and Insurer: GBG Insurance Limited

14.0 SUBSCRIPTION AGREEMENT

I hereby apply to be a Plan Participant of the Multi-National 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.

Insured By:

GBG Insurance Limited

DIALCARE®

PHYSICIAN ACCESS

GBG
Insurance Without Borders℠

DialCare®
PHYSICIAN ACCESS

DISCLOSURE: THIS PLAN IS NOT INSURANCE AND IS NOT INTENDED TO REPLACE HEALTH INSURANCE.

DialCare PHYSICIAN ACCESS

GBG Insurance Without Borders™

Physician Access

DialCare Physician Access is a modern, easy-to-use telemedicine solution for non-emergency illnesses and general care. You have direct access to state-licensed and fully credentialed doctors, via phone or video consultations, to receive treatment and advice for common ailments, including colds, the flu, rashes and more. Doctors are available 24 hours a day, 365 days a year, allowing students convenient access to quality care while studying and traveling in the U.S. When medically appropriate, a DialCare doctor may prescribe a short term, non-DEA controlled medication that you can pick up at the pharmacy of your choice. You are responsible for making sure the pharmacy chosen is part of your network. Please refer to your policy for information.

When to use DialCare Physician Access:

- For non-emergency medical issues, questions and concerns
- During or after normal business hours, nights, weekends and holidays
- If you live a significant distance from a primary care doctor
- When a primary care doctor is not available
- When traveling and in need of non-urgent medical care or advice

What conditions can be treated?

- Allergies
- Fever
- Respiratory infections
- Asthma
- Gout
- Sinus infections
- Bronchitis
- Insect bites
- Skin inflammations
- Cold & flu
- Sore throat
- Digestive issues
- Joint aches & pains
- Sports injuries
- Ear infections
- Rashes
- Urinary tract infections
- And more!

How to Access:

1. To register, follow the link you received in the confirmation email, download the DialCare mobile app or visit dialcare.com/verify. If you're having problems registering, you can call DialCare at **(855) 335-2255** for assistance.
2. Once registered, you can log in at member.dialcare.com or through the mobile app to begin requesting consults and to update your medical history. You can also call us at **(855) 335-2255**.

DISCLOSURE: THIS PLAN IS NOT INSURANCE AND IS NOT INTENDED TO REPLACE HEALTH INSURANCE.
State restrictions list is available at dialcare.com/states.

DialCare
PHYSICIAN ACCESS

GBG
Insurance Without Borders™

Terms & Conditions

Terms and Conditions: DialCare, LLC ("DialCare") is an affiliate company of Careington International Corporation. DialCare provides administrative services to DialCare clinicians. The Terms and Conditions define the obligations of DialCare, its authorized agents and yourself, and they establish the basic rules of safe and fair use of DialCare's public website, member website, and services (Services). DialCare and its authorized agents reserve the right to immediately and without advance notice terminate the Services and deny access to individuals who do not abide by the Terms and Conditions. DialCare reserves the right to terminate plan members from its plan for any reason. Additional Terms and Conditions are located at www.dialcare.com.

Limitations, Exclusions & Exceptions: This plan is a telemedicine program offered by DialCare. DialCare is not a licensed insurer, health maintenance organization or other underwriter of health care services. This plan is not insurance. DialCare is not licensed to provide and does not provide health care services or items to individuals. Telemedicine consultations are provided by physician entities that are contracted with DialCare. Physicians contracted by DialCare are solely responsible for the professional advice and treatment rendered to members and DialCare disclaims any liability with respect to such matters. DialCare may not be available in all states, and certain methods of telemedicine consultations (e.g., phone, video) may not be available per state law. Consultation times are not guaranteed. Telemedicine consultations are not appropriate for emergencies or other medical issues requiring in-person care. You must immediately dial "911" or seek in-person treatment in the event of a medical emergency, or if instructed to do so by a DialCare physician. DialCare reserves the right to deny care for potential misuse of services. You are obligated to pay for all health care services resulting from consultations. Services and service providers may change or be discontinued at anytime with notice as required by law.

Complaint Procedure: If you would like to file a complaint, you must submit your complaint in writing to:
DialCare, P.O. Box

2568, Frisco, TX 75034.

Disclosures: THIS PLAN IS NOT INSURANCE and is not intended to replace health insurance. This plan does not meet the minimum creditable coverage requirements under M.G.L. c.111M and 956 CMR 5.00. This plan is not a Qualified Health Plan under the Affordable Care Act. The range of discounts will vary depending on the type of provider andservice. The plan does not pay providers directly. Plan members must pay for all services but will receive a discount from participating providers. The list of participating providers is at www.careington.com. A written list of participating providers is available upon request. You may cancel within the first 30 days after effective date or receipt of membership materials (whichever is later) and receive a full refund, less a nominal processing fee (nominal fee for MD residents is $5, AR and TN residents will be refunded processing fee). Discount Plan Organization and administrator: Careington International Corporation, 7400 Gaylord Parkway, Frisco, TX 75034; phone 800-441-0380.

Global Benefits Group (GBG) is the marketing name used to refer to the administrative operations of Global Benefits Group, Inc. and its subsidiaries and affiliates. GBG does notadminister the telemedicine program, and is not an affiliate, agent or principal of the program. The relationship between GBG and DialCare is that of independent contractors.