GLOBAL STUDENT ACCESS
Comprehensive Health Insurance Policy
Thank you for selecting Global Student Access Health Insurance.
Welcome to the Global Benefits Group (GBG) family!

Welcome to the Global Benefits Group (GBG) family! We understand you have a choice in insurance providers, and thank you for placing your trust in GBG.

This Policy outlines the terms and conditions of the benefits covered by this plan. It also contains other important information about how to contact us and how to use your coverage. Please review the Policy Face Page which shows the deductible you selected and any exclusions or amendments to your coverage.

An Acknowledgment of Receipt and an Authorization Form is also included which require your signature. Please sign these documents and return to GBG immediately. You may keep the originals.

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 throughout the year.

Sincerely,

Ed Zutler
President, GBG Insurance Limited
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Schedule of Benefits

**CLASSES OF ELIGIBLE PERSONS:**
A person may be covered only under one Class of Eligible Persons even though He or She may be eligible under more than one class. Also, a person may not be covered as a Dependent and a Covered Person at the same time.

**Class 1:** Non-United States students traveling outside their Home Country and has his or her true, fixed and permanent home and principal establishment outside of the United States and holds a current and valid passport with visa.

**ELIGIBILITY WAITING PERIOD:** NONE

After the Deductible has been satisfied, benefits will be paid as listed for the Provider selected based on Usual, Reasonable, and Customary Charges.

<table>
<thead>
<tr>
<th>Emergency Hospitalization and Inpatient Benefits</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Hospital Accommodations; Semi-private room</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Nursing fees, medical expenses, ancillary charges, fees for surgeons</td>
<td>100% UCR</td>
</tr>
<tr>
<td></td>
<td>$5,000 Maximum per injury or sickness</td>
</tr>
<tr>
<td>Intensive Care (If medically necessary)</td>
<td>100% of UCR</td>
</tr>
<tr>
<td>Medical Practitioner</td>
<td>100% of UCR, Limited to $500 per legally qualified practitioner</td>
</tr>
<tr>
<td></td>
<td>Per injury or sickness</td>
</tr>
<tr>
<td>Emergency Medical treatment, medicine or drugs, laboratory, Diagnostic test and pre-admission tests</td>
<td>100% of UCR</td>
</tr>
<tr>
<td>Emergency Related MRI, PET, and CT scans, X-Rays, pathology, diagnostic tests and procedures, Oncology tests, drugs and consultants’ fees, including cover for chemotherapy and radiotherapy</td>
<td>100% of UCR</td>
</tr>
<tr>
<td>Emergency Medical Coverage for injuries or illness sustained from mental health or substance abuse</td>
<td>100% of UCR</td>
</tr>
<tr>
<td></td>
<td>$25,000 Maximum per Policy Period</td>
</tr>
<tr>
<td>Injuries caused from motor vehicle accidents</td>
<td>100% of UCR</td>
</tr>
<tr>
<td>(Travel in or upon, alighting to or from, working on or around any motorcycle recreational vehicle including but not limiting to: two – or three- wheeled motor vehicle: four wheeled all-terrain vehicle (ATV); snowmobile)</td>
<td>100% of UCR</td>
</tr>
<tr>
<td></td>
<td>$15,000 maximum per Policy Period</td>
</tr>
</tbody>
</table>

**Other Emergency Treatment**

| Emergency Medical Evacuation                                                         | 100% of UCR                                                     |
| Transportation to the nearest available medical facilities, relative to Inpatient & Medical Evacuation must be coordinated and approved by GBG assist | $250,000 Maximum per Policy Period;                              |
| Emergency Local Ambulance                                                            | 100% of UCR                                                     |
| Transportation to the nearest and appropriate hospital. Ground Ambulance paid at $400 maximum, per trip and $2,500 maximum per Policy Period |                                               |
| Emergency Room and Emergency Medical Services                                        | 100% UCR                                                        |
| Must be rendered within 72 hours of time of injury or first onset of sickness         |                                                                 |
### Emergency Dental Care
Limited to accidental injury of sound natural teeth sustained while covered under the policy ($100 maximum per tooth; $2000 maximum per policy period.)
Treatment must be initiated within 48 hours from date emergency begins and be completed within 30 days of the date of the accident or injury.
Emergency treatment for relief of dental pain, other than a blow to the face, up to maximum $600 per policy period. Treatment must be initiated within 48 hours from date emergency begins and be completed within 30 days of the date of the accident or injury.

### Outpatient Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Benefit Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Treatment</td>
<td>Provided by a psychologist as prescribed by a licensed and qualified physician due to trauma from a covered emergency on an outpatient basis, or at a medical facility licensed for treatment must be initiated within 90 days of a covered emergency $1,000 maximum benefit per policy period. 6 visit maximum.</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Outpatient Surgery related to an Emergency</td>
<td>Miscellaneous: Related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees, (outpatient surgeon and anesthetists); anesthesia, drugs or medicines; and supplies $5,000 maximum per surgery</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Private Duty Nursing, Skilled Nursing, Visiting Nurse</td>
<td>Does not cover services provided by a family member Must be for care related to an emergency Annual Benefit Maximum: 120 Days Per Year</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Extended Care / Inpatient Rehabilitation</td>
<td>Pre-Authorization Required Must be confined to facility immediately following a Hospital stay caused by an emergency Acute or sub-acute care only for Extended Care Episode</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Physiotherapy after an Emergency</td>
<td>Includes (but not limited to): Physical therapy 1. Occupation therapy 2. Cardiac rehabilitation therapy 3. Manipulative treatment 4. Speech therapy (will be paid for only for the treatment of speech, language, voice or communication and auditory processing when the disorder result from injury, trauma, stroke, surgery, cancer or vocal nodules.) Review of Medical Necessity will be performed after 12 visits per Injury ($50 maximum per visit. Benefits are payable for Injury only.)</td>
<td>100% UCR</td>
</tr>
<tr>
<td></td>
<td>There are no Physiotherapy benefits for Sickness Coverage for both inpatient and out-patient treatment. Pre-authorization is required by GBG Assist.</td>
<td></td>
</tr>
</tbody>
</table>
Emergency treatment by a chiropractor, osteopath, or podiatrist
$500 Maximum practitioner per Policy Period
Pre-Authorization required by GBG Assist

Durable Medical Equipment
$5,000 Maximum per Policy Period
Written prescription must accompany claim when submitted
Benefits are limited to initial purchase or one replacement purchase per Policy period as a result of an Emergency
Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted in the body
Pre-Authorization required by GBG Assist as a result of an Emergency

Acupuncture Treatment for Covered Illness as Result of an Emergency
100% UCR
$500 Maximum per Policy Period

Injuries Resulting from physical fitness activities including intramural sports
Covered per other illness or injury
$150,000 Maximum per Policy Period

Repatriation of Mortal Remains
Pre-Authorization required by GBG Assist
$25,000

Bonus Benefits

Passport Recovery
Reimbursement for the cost of passport replacement based on loss, theft or damage to your passport
$750

ATM Safe
Provides lost cash replacement for losses occurring during robbery at an ATM
$400

Accidental Death and Dismemberment. Including common carrier.
$25,000 AD&D
$100,000 Common Carrier

Travel Benefits
Lost Baggage
Expense Reimbursement due to flight delays
Maximum $250

24/7 Emergency Assistance Call Center
Unlimited
Available through GBG Assist

NOTES:

• We do not pay benefits for the amount of Eligible Expenses paid by You as Your Coinsurance or Co-pay amount.

• Eligible Expenses will be paid under the Inpatient benefits for Surgery and under the Outpatient benefits for Surgery, but not both for the same or related procedure.

Network Provider Arrangements

There are no Network Provider arrangements for use with this Policy. You are able to utilize any Provider, regardless of their Network Affiliation. Providers will bill you for expenses in excess of policy benefits. You will be responsible for all out-of-pocket expenses in excess of the insurance policy limitations contained in the Schedule of Medical Expense Benefits. Eligible Physician and Hospital Services will be paid at 100% of Usual, Customary and Reasonable charges.
Travel Arrangement Benefits

Passport Recovery: Reimbursement for the Cost of passport replacement based on loss, theft or damage to your passport  
$750 per Policy Period

Baggage Loss Benefit  
$250 per Occurrence

Baggage Delay Benefit  
$250 per Occurrence

ATM Safe Benefit  
$400 Maximum per Policy Period

Definitions

The male pronoun includes the female whenever used.
For the purposes of the Policy the capitalized terms used herein are defined as follows:
Additional terms may be defined within the provision to which they apply.

Accident means an unforeseeable event which:
1) Causes Injury to one or more Covered Persons; and
2) Occurs while coverage is in effect for the Covered Person.

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

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

Baggage and Personal Effects means luggage, personal possessions and travel documents, including a Passport, taken by the Covered Person on the Covered Person’s Trip.

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

Business Partner means an individual who (a) is involved in a legal general partnership with the Covered Person and (b) is actively involved in the day to day management of the Covered Person’s business.

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

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

Company means Global Benefits Group. Also hereinafter referred to as We, Us and Our.

Complications of Pregnancy means a condition which:
- When pregnancy is not terminated, requires medical treatment and whose diagnosis is distinct from pregnancy but is adversely affected by or are caused by pregnancy, such as: (a) acute nephrits; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; and (i) other similar medical and surgical conditions of comparable severity related to pregnancy.

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

Complications of Pregnancy will not include:
- False Labor;
- Occasional spotting;
- Physician prescribed rest during the period of pregnancy;
- Morning Sickness; and
- Similar conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.
Delivery by cesarean section is considered a complication of pregnancy if the cesarean section is non-elective. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the Child or mother.

**Covered Person** means a Person and Dependent eligible for coverage as identified in the Application who is a non-U.S citizen, resides temporarily, in the United States for whom proper premium payment has been made when due, and who is therefore a Covered Person under the Policy.

**Covered Vehicle** means a private passenger vehicle owned by or under long term lease (1 year or more) to the Covered Person.

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

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

**Emergency** means a Sickness or Injury for which the Covered Person seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause:
- His life or health would be in serious jeopardy, or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn Child
- His bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

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

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

**Home Country** means the country where a Covered Person has his or her true, fixed and permanent home and principal establishment and holds a current and valid passport.

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

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

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

Home Health Care consists of, but shall not be limited to, the following:
- Part time and intermittent skilled nursing services: services given to the Covered Person at least once every 60 days or as frequently as a few hours per day, several days per week.
- Therapeutic services: physical therapy occupational therapy; speech and hearing therapy; and
- Medical social services, medical supplies, drugs and medicines, related pharmaceutical services and laboratory services to the extent such charges or costs would have been covered under this Certificate if the Covered Person had remained in the Hospital.

**Host Country** means the United States.

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

1) Operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons;
2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call;
4) Has a staff of one or more licensed Physicians available at all times;
5) Provides organized facilities for diagnosis, treatment and surgery, either
a) on its premises; or
b) facilities available to it, on a pre-arranged basis;

6) Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
7) Is not a place for drug addicts, alcoholics or the aged.

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

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

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

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

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

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

Inpatient means a Covered Person who is confined in an institution and is charged for room and board.

Insurance means the coverage that is provided under the Policy.

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

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

Maximum Benefit means the largest total amount of Eligible Expenses that the Company will pay for the Covered Person as shown in the Covered Person’s Schedule of Benefits as found on the ID card.

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

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

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

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

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:
- Is Experimental/Investigational or for research purposes;
- Is provided for education purposes or the convenience of the Covered Person, the Covered Person’s family, Physician, Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the person’s condition or the quality of medical care;
- Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
- Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- It can be safely provided to the patient on a less cost effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.
Mental or Nervous Disorder means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder on the date the medical care or treatment is rendered to a Covered Person.

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

Natural Disaster means a flood, hurricane, tornado, earthquake, mudslide, tsunami, avalanche, landslide, volcanic eruption, fire, wildfire or blizzard that is due to natural causes.

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

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

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

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

Permanent Residence means the country where a Covered Person has his or her true, fixed and permanent home and principal establishment, and to which he or she has the intention of returning and holds a current and valid passport.

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

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

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

Pre-Existing Condition means an Injury, Sickness, disease, or other condition which has been stabilized for the 90 days prior to the policy inception date.

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

1) A Hospital or a special unit of a Hospital designated as a Rehabilitation Facility; or
2) A free standing facility.

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

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

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

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

We, Our, Us means Global Benefits Group underwriting this insurance.

You, Your, Yours, He or She means the Covered Person who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.
Eligibility for Insurance

Person eligible to be a Covered Person under the Policy are those persons described as an ELIGIBLE CLASS on the Application Schedule of Benefits. This includes anyone who may become eligible while the Policy is in force.

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

A Covered Person’s Dependent(s), as applicable, are eligible on the latest of the date:

1) the Covered Person is eligible, if the Covered Person has Dependents on that date; or
2) the date the person becomes a Dependent; or

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

Effective Dates of Insurance

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

Covered Person’s Effective Date for Travel Delay Coverage:

Coverage begins after the Covered Person has traveled 60 miles or more from home en route to join their Trip. This is the Covered Person’s “Effective Date” and time for Travel Delay.

Covered Person’s Effective Date for all other Coverages:

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

1) The Effective Date of the Policy; or
2) The date the Company receives a completed application or enrollment form; or
3) The moment He departs their Home Country airspace or
4) The Date the Company approves the Application

Termination Date of Insurance

Policy Termination Date

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

The Policy terminates automatically on the earlier of:

1) The Policy Expiration Date shown in the Policy; or
2) The Policy may be terminated by the Policyholder or the Company as of any premium due date by giving written notice to the other and the Participating Organization at least 31 days prior to such date.

The Policyholder and the Company may terminate the Policy at any time by written mutual consent.

Termination Date of the Participating Organization. Coverage for a Participating Organization will terminate on the earliest of the following dates:

1) The date the Participating Organization no longer meets the definition of a Participating Organization; and
2) The last day of a Coverage Month, if the Participating Organization has given the Company at least 30 calendar days prior written notice.

Termination of the Policy, or termination of coverage for a Participating Organization, under any conditions will be without prejudice to any claim incurred prior to termination.

Covered Person’s Termination Date for all other Coverages:

Insurance for a Covered Person will end on the earliest of:

1) The date He is no longer in an Eligible Class; or
2) The date the Covered Person returns to his or her Home Country unless otherwise covered under the Policy; or;
3) The date shown on the Certificate issued by the Company or
4) The date the participating organization is no longer eligible to sponsor coverage under the Policy
Premium Provisions

Premiums:
The Company provides insurance in return for premium payments. Premium due dates are the first of every month unless otherwise stated in the Policy. Premium payment made in advance or for more than a one month period will not affect any provisions of the Policy with regard to change.

Failure by the Covered Person to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

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

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

Scope of Coverage
Benefits are payable under the Policy for Eligible Expenses incurred by a Covered Person for the items stated in the, Schedule of Benefits. Benefits will be payable to either the Covered Person or the Service Provider for Eligible Expenses incurred except for Home Country coverage as stated in the, Schedule of Benefits, Home Country Coverage. Coverage is available 24 hours per day while traveling to, from and while at the Covered Person’s destination.

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

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

1) Is within the scope of the DESCRIPTION OF BENEFITS PROVISIONS; and
2) Occurs while the person is a Covered Person under the Policy.

Coordination of Benefits Provision
If a Covered Person is covered for Benefits under the Policy, and is also covered for these Benefits under one or more other Plans, the benefits payable under the Policy will be coordinated with the benefits payable under all other Plans.

Coordination of Benefits will be used to determine the benefits payable for a Covered Person for any Claim Determination Period if, for the Allowable Expenses incurred in that period, the sum of (1) and (2) below would exceed those Allowable Expenses:

1) The benefits that would be payable under the Policy without coordination; and
2) The benefits that would be payable under all other Plans without the coordination of benefits provisions in those Plans.

The benefits that would be payable under the Policy for Allowable Expenses incurred in any Claim Determination Period without Coordination of Benefits will be reduced to the extent required so that the sum of:

1) Those required benefits; and
2) All the benefits payable for those Allowable Expenses from all other Plans will not exceed the total of those Allowable Expenses.

Benefits payable under all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of the Policy are determined if:

1) The Benefit Determination Rules would require the Policy to determine its benefits before that Plan; and
2) The other Plan has a provision that coordinates its benefits with those of the Policy and would, based on its rules, determine its benefits after the Policy.

When Coordination of Benefits reduces the total amount otherwise payable in a Claim Determination Period for a Covered Person, each benefit that would be payable in the absence of Coordination of Benefits will be reduced in proportion. The reduced amount will be charged against any applicable benefit limit of the Policy.
We reserve the right to release to or obtain from any other insurance company or other organization or person, any information that, in Our opinion, We or it needs for the purpose of the Coordination of Benefits.

When payments that should have been made under the Policy based on the terms of this provision have been made under any other Plans, We have the right to pay to any other organization making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered benefits paid under the Policy. We will be released from all liability under the Policy to the extent of these payments. When an overpayment has been made by us, at any time, We will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance company or organization, as We may determine.

Benefit Determination Rules - The rules below establish the order in which benefits will be determined:

1) Benefits not as a Dependent:
   The benefits of a Plan that covers the person for whom claim is made other than as a dependent will be determined before a Plan that covers that person as a dependent.

2) Benefits for Person Longest Covered:
   When the above rules do not establish the order, the benefits of a Plan that has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time.

Right to Receive and Release Necessary Information

For this section to work, We must exchange information with other plans. To do so, We may give to or get from any source all such information necessary. This will be done without the consent of or notice to any person. Any people claiming Benefits under this plan must give Us the required information.

Description of Benefits

PART A: ACCIDENT AND SICKNESS BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

If, within one year from the date of an Accident or Injury covered by the, the Covered Person suffers from a Covered Loss listed below, We will pay the percentage of the Principal Sum set opposite the loss in the table below [other than while covered for Common Carrier Only Benefits. If the Covered Person sustains more than one such Loss as the result of one Accident, We will pay only one amount, the largest to which he is entitled. This amount will not exceed the Principal Sum which applies for the Covered Person. The Principal Sum is the Maximum Benefit Amount shown in Schedule of Benefit.

Benefits are payable if such Injury:

1) Occurs during the course of time the Covered Person is covered under the Policy;

2) is sustained during such Trip while the Covered Person is riding as a passenger (but not as a pilot, operator or member of the crew) in or on, boarding or alighting from:
   a) any civilian aircraft having a current and valid Airworthiness Certificate, and piloted by a person who then holds a valid and current certificate of competency of a rating authorizing him to pilot such aircraft] or
   b) any transport type aircraft operated by the Military Airlift Command (MAC) of the United States, or by the similar air transport service of any duly constituted governmental authority of any other recognized country or
   c) a Common Carrier

   provided that this Insurance will not apply while such Covered Person is riding in any civilian or military aircraft other than as expressly described above, unless previously consented to in writing by the Company.

3) While upon airport premises designated for passenger use immediately before boarding or immediately after alighting from an aircraft on which the Covered Person is covered by the Covered Person’s Policy.

Under no circumstances will the Company pay more than the Covered Person’s Principal Sum for all Covered Losses combined, including this Coma Benefit, which are incurred as the result of the same Accident.

The Covered Person’s designated beneficiary is responsible for providing the Company proof of continuing Coma. The Company reserves the right, at the end of the first 30 consecutive days of Coma and as often as it may reasonably require thereafter, to determine, on the basis of all the facts and circumstances, that the Covered Person is in a Coma, including, but not limited to, requiring an independent medical examination provided at the expense of the Company.

Covered Accident Medical Expenses incurred due to Injury only are paid up to the maximum Accident Medical Expense Benefit Limit, for the following eligible expenses: treatment by a Physician; care or service from a Hospital; services provided by an ambulatory medical-surgical facility; Home Health Care from a licensed home health agency, but only if continued Hospital care would have otherwise been required; attendance of a graduate Registered Nurse; X-ray examination; or, use of an ambulance.
The Covered Person must receive initial medical treatment within 30 days of the date of Accident. Eligible Medical Expenses must be incurred within 52 weeks of the date of Accident. This insurance does not cover injuries received while making a parachute jump (unless to save a life).

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS/Common Carrier

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Class 1 Principal Sum $25,000
Common Carrier $100,000
Time Period for Loss 90 days

Loss of: Benefit: Percentage of Principal Sum
Loss of Life
Loss of Both Hands 100%
Loss of Both Feet 100%
Loss of Entire Sight of Both Eyes 100%
Loss of One Hand and One Foot 100%
Loss of One Hand and Entire Sight of One Eye 100%
Loss of One Foot and Entire Sight of One Eye 100%
Loss of One Hand 100%
Loss of One Foot 50%
Loss of Sight of One Eye 50%

Description of Accident and Dismemberment Benefits

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

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.

The covered Person must receive initial medical treatment within 30 days of the date of Accident. The insurance does not cover injuries received while making a parachute jump (unless to save a life).

The maximum amount payable for this benefit is $25,000. If the Insured incurs a covered loss listed above, we will pay the percentage of the Principal Sum opposite the loss in the table above. If the covered person sustains more than one such loss as the result of one accident, the Insurer will only pay one amount, the largest to what the insured is entitled. The loss must result within 90 days of the accident. Your coverage under the policy must be in force.
Accident & Sickness Medical Expense Benefits

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

<table>
<thead>
<tr>
<th>Lifetime Maximum</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Maximum</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Annual Maximum Per Covered Person in Home Country Per Policy Period</td>
<td>$15,000</td>
</tr>
<tr>
<td>Deductible per Policy Period (Inpatient Only)</td>
<td>$250</td>
</tr>
<tr>
<td>Co-Payments at Student Health Center and Office Visit For Emergency Care</td>
<td>$20</td>
</tr>
</tbody>
</table>

All Services except Preventive Care are for emergency treatment only, not routine health care.

Emergency and Sickness Medical Expense Benefits

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

Accident and Sickness Medical Expense Benefits are only payable:

1) for Usual, Reasonable and Customary Charges incurred after the Deductible has been met;
2) for those Emergency Eligible Expenses incurred by or on behalf of the Covered Person;
3) for Eligible Expenses incurred within 30 days after the date of the Eligible Expense.

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

Each Eligible Medical Expense listed below will be in-or-out depending on the plan selected by the Policyholder. However, any benefits required by state law/regulation will always be included.

Eligible Medical Expenses include:

1) **Nursing Services** – Outpatient Charges for nursing services by a Registered Nurse or Licensed Professional. Does not cover services provided by a family member. Services must be for care related to an emergency.

2) **Skilled Nursing Facility** - charges for services as described in the schedule of benefits. The benefit provides skilled nursing 24 hours a day, seven days a week, under the supervision of a registered nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A SNF provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence.

A SNF confinement must take place within 14 days from a hospital discharge and must represent care for the same condition which required hospitalization that lasted a minimum of three days. Care may not be custodial in nature (e.g., care which could be performed at home). The facility may not be primarily a place which provides general care for the aged.

3) **Hospice Care Benefit** as follows:
   a) nursing care by a Registered Nurse; or a licensed practical Registered Nurse, a vocational Registered Nurse, or a public health Registered Nurse who is under the direct supervision of a Registered Nurse;
   b) physical therapy [and speech therapy] when rendered by a licensed therapist;
c) medical supplies, including drugs and the use of medical appliances;
d) physician’s services; and
e) services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.

4) Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.

5) Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items.

Additional Benefits

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

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

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

Surgeon (In or Outpatient) Benefits for Emergency Treatment
We will pay charges for:

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

2) A Physician, for assistant surgeon duties up to the Maximum Benefit shown in the Schedule of Benefits.
Assistant Surgeon Benefit for Treatment
If, in connection with such operation, a Covered Person requires the services of an Assistant Surgeon, We will pay the Covered Percentage of the Covered Expense incurred.

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

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

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

Emergency Ambulance Benefit
When, by reason of Injury or Sickness a Covered Person requires the use of a community or Hospital Ambulance in a Medical Emergency, We will pay a Benefit Amount up to a Maximum shown in the schedule, within the metropolitan area in which the Covered Person is located at that time the service is used. Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, the scene of the Accident or Medical Emergency to a Hospital or between Hospitals. Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area. Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness or if the Covered Person is in a rural area, then air ambulance transportation to the nearest metropolitan area will be considered a Eligible Expense. Air Ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

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

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

Consultant Physician Benefit Following a Covered Emergency
If, by reason of Injury or Sickness, a Covered Person requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending Physician for the purpose of confirming or determining a diagnosis, We will pay the Covered Percentage of the Covered Expenses incurred.

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

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

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

If a Student seeks treatment at the Student Health Center and treatment is not possible at the Student Health Center and a student is referred to the ER, co-payments for the Emergency Room will be half of the scheduled amount.

In the event treatment is sought and is not available at the Student Health Center and the Student is referred to the Emergency Room, and then subsequently hospitalized; the Emergency Room visit and subsequent Hospital Confinement co-payments will be integrated to a maximum of $250.
Mental and Nervous Conditions Expense Benefit Following A Covered Traumatic Incident
If a Covered Person requires treatment for a Mental or Nervous Condition as outlined above, We will pay for such treatment as follows:

Mental Health Treatment Provided by a psychologist as prescribed by a licensed and qualified physician due to trauma from a covered emergency on an outpatient basis, or at a medical facility licensed for treatment.

Must be limited within 90 days of a covered emergency

Benefits for Inpatient Hospital Confinement Following a Covered Emergency
When a Covered Person requires Hospital Confinement for treatment of a Mental or Nervous Condition, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement.

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

Emergency Dental Expense Benefit
We will pay benefits as described in the Schedule of Benefits for expenses for emergency dental treatment due to injury to natural teeth. Only expenses for emergency dental treatment to natural teeth incurred during the Trip will be reimbursed. Expenses incurred after the Trip are not covered.

Physiotherapy Expense Benefit
We will pay benefits as described in the Schedule of Benefits for eligible Physiotherapy expenses incurred by the Covered Person as a result of an emergency accident or illness. We will pay Usual, Reasonable and Customary expenses in excess of the Deductible as stated in the Schedule of Benefits. In no event will the Company’s maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Expenses during any one period of individual coverage.

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

Physiotherapy after an emergency includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy. Speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from injury, trauma, stroke, surgery, cancer or vocal nodules. For outpatient Physiotherapy, as a result of an emergency, review of Medical Necessity will be performed after 12 visits per Injury. ($50 maximum per visit. Benefits are payable for Injury only. There are no Physiotherapy benefits for Sickness.) Coverage for both inpatient and out-patient treatment. Pre-authorization required by GBG Assist.

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

Durable Medical Equipment Expense Benefit
If, by reason of Injury or Sickness, a Covered Person requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Eligible Expenses incurred by a Covered Person for such Durable Medical Equipment. A written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year, as a result of an Emergency. Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted in the body. Pre-authorization required by GBG Assist as a result of an Emergency. We pay the Covered Percentage of the Eligible Expenses incurred by a Covered Person for the purchase or rental of such item. In no event shall we pay rental charges in excess of the purchase price. Any rental charges paid will be applied toward the cost of the purchase price if the equipment is purchased at a later date. If Durable Medical Equipment is purchased, it is Our property and is to be returned to Us, at Our expense, upon completion of a Covered Person's need, if so requested by Us.

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

Durable Medical Equipment means medical equipment that:
1) is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
2) can withstand long-term repeated use without replacement;
3) is not useful in the absence of an Injury or Sickness; and
4) can be used in the home without medical supervision.
Emergency Medical Evacuation, Medical Repatriation and Return of Remains

When you suffer loss of life for any reason or incur a sickness or injury during the course of your trip, the following benefits are payable, up to the Maximum Benefit Amount shown in the Schedule of Benefits.

1) Emergency Medical Evacuation: If the local attending legally qualified physician and GBG assist determine that transportation to a hospital or medical facility is medically necessary to treat an unforeseen sickness or injury which is acute or life threatening and adequate medical treatment is not available in the immediate area, the transportation expense incurred will be paid for the usual and customary charges for transportation to the closest hospital or medical facility capable of providing that treatment.

   If you are traveling alone and will be hospitalized for more than 10 consecutive days and emergency evacuation is not imminent, benefits will be paid to transport one person, chosen by you, by economy transportation, for a single visit to and from your bedside.

2) If the local attending legally qualified physician and GBG assist determine that it is medically necessary for you to return to your primary place of residence because of an unforeseen sickness or injury which is acute or life threatening, the transportation expense incurred within 30 days from the date of the covered loss, will be paid for your return to your primary place of residence or to a hospital or medical facility closest to your primary place of residence capable of providing continued treatment via one of the following methods of transportation, as approved, in writing, by GBG assist:
   a) one-way economy transportation;
   b) commercial air upgrade to business or first class, based on your condition as recommended by the local attending legally qualified physician and verified in writing and considered necessary by the GBG medical advisor or
   c) other covered land or air transportation including, but not limited to, commercial stretcher, medical escort, or the usual and customary charges for air ambulance, provided such transportation has been pre-approved and arranged by the GBG medical advisor.

   Transportation must be via the most direct and economical route.

3) Return of Remains: In the event of your death during a trip, the expense incurred within 30 days from the date of the covered loss will be paid for minimally necessary casket or air tray, preparation and transportation of your remains to your primary place of residence in the United States of America or to the place of burial.

Out-Patient Prescription Drug Benefit

We will pay the eligible expenses, subject to the deductible amount shown in the schedule of benefits, if any, for a prescription drug or medication when prescribed by a physician on an outpatient basis due to a covered emergency.

Prescription Drug means a drug which:

1) Under federal law may only be dispensed by written prescription; and
2) Is utilized for the specific purpose approved for general use by the food and drug administration.

The prescription drug must be dispensed for the outpatient use by the covered person:

1) On or after the covered person's effective date; and
2) By a licensed pharmacy provider.

Benefits are payable up to the maximum benefit amount shown on the schedule of benefits.

Part B: Travel Arrangement Benefits

Baggage Loss Benefit

Benefits will be provided to the covered person, up to the maximum benefit amount shown in the covered person's schedule of benefits: (a) against all risks of permanent loss, theft or damage to the covered person's baggage and personal effects; (b) subject to all general exclusions and the additional limitations and exclusions specific to baggage and personal effects in the covered person's plan; and (c) occurring while coverage is in effect. For the purposes of this benefit: "Baggage and Personal Effects" means goods being used by the covered person during the covered person's trip, including personal diving equipment.

Valuation and Payment of Loss: The lesser of the following amounts will be paid:

1) the actual cash value at the time of loss, theft or damage, except as provided below;
2) the cost to repair or replace the article with material of a like kind and quality; or
3) $250 per article.
For claimed items without original receipts, payment of loss will be calculated based upon 90% of the Actual Cash Value at the time of loss, not to exceed $250 per article.

The Company may take all or part of a damaged Baggage as a condition for payment of loss. In the event of a loss to a pair or set of items, the Company will:

1) repair or replace any part to restore the pair or set to its value before the loss; or
2) pay the difference between the value of the property before and after the loss.

A combined maximum of $250 will be paid for jewelry; precious or semi-precious stones; watches; articles consisting in whole or in part of silver, gold or platinum; furs or articles trimmed with fur; cameras and their accessories and related equipment, computer, digital or electronic equipment or media.

A maximum of $750 will be paid for the cost of replacing a passport or visa.

**Baggage and Personal Effects does not include:**

1) animals;
2) automobiles and automobile equipment;
3) boats or other vehicles or conveyances;
4) trailers;
5) motors;
6) aircraft;
7) bicycles, except when checked as baggage with a Common Carrier;
8) household effects and furnishings;
9) antiques and collectors items;
10) artificial limbs or other prosthetic devices;
11) prescribed medications;
12) keys, money, stamps and credit cards (except as otherwise specifically covered herein);
13) securities, stamps, tickets and documents (except as coverage is otherwise specifically provided herein);
14) sporting equipment if the loss results from the use thereof; or
15) telephones or PDA devices, computer hardware or software;

**Baggage Delay Benefit**

Baggage Delay: If, while on a Trip, the Covered Person's checked baggage is delayed or misdirected by a Common Carrier for more than 12 hours from the Covered Person's time of arrival at a destination other than the Covered Person's return destination, benefits will be paid, up to the Maximum Benefit Amount shown in the Covered Person's Schedule of Benefits, for the actual expenditure for necessary personal effects. The Covered Person must be a ticketed passenger on a Common Carrier. The Common Carrier must certify the delay or misdirection. Receipts for the purchases must accompany any claim.

The Company will also reimburse the Covered Person up to $250 for expenses incurred during the Covered Person’s Trip to expedite the return of the Covered Person’s delayed Baggage. This coverage terminates upon the Covered Person’s arrival at the return destination of the Covered Person’s Trip.

Baggage Delay: The Company will reimburse the Covered Person, less any amount paid or payable from any other valid and collectible insurance or indemnity, up to the amount shown in the Covered Person’s Schedule of Benefits, for the cost of reasonable additional clothing and personal articles purchased by the Covered Person, if the Covered Person’s Baggage is delayed for 12 hours or more during the Covered Person’s Trip.

The Company will also reimburse the Covered Person up to $250 for expenses incurred during the Covered Person’s Trip to expedite the return of the Covered Person’s delayed Baggage. This coverage terminates upon the Covered Person’s arrival at the return destination of the Covered Person’s Trip.

Benefits are not payable for any loss caused by or resulting from:

1) breakage of brittle or fragile articles;
2) wear and tear or gradual deterioration;
3) confiscation or appropriation by order of any government or custom’s rule;
4) theft or pillage while left in any unlocked or unattended vehicle;
5) property illegally acquired, kept, stored or transported;
6) the Covered Person’s negligent acts or omissions; or
7) property shipped as freight or shipped prior to the Scheduled Departure Date;
8) electrical current, including electric arcing that damages or destroys electrical devices or appliances.

Additional Provisions applicable to Baggage and Personal Effects and Baggage Delay:
Benefits will not be paid for any expenses which have been reimbursed or for any services which have been provided by the Common Carrier, hotel or Travel Supplier; nor will benefits be paid for loss or damage to property specifically scheduled under any other insurance.

Additional Claims Provisions Specific to Baggage

Covered Person’s Duties After Loss of or Damage to Property or Delay of Baggage: In case of loss, theft, damage or delay of baggage or personal effects, and Covered Person must:

1) take all reasonable steps to protect, save or recover the property;
2) promptly notify, in writing, either the police, hotel proprietors, ship lines, airlines, railroad, bus, airport or other station authorities, tour operators or group leaders, or any Common Carrier or bailee who has custody of the Covered Person’s property at the time of loss;
3) produce records needed to verify the claim and its amount, and permit copies to be made;
4) send proof of loss as soon as reasonably possible after date of loss, providing date, time, and cause of loss, and a complete list of damaged/lost items; and
5) allow the Company to examine baggage or personal effects, if requested.

These benefits will not duplicate any other benefits payable under the Covered Person’s Plan or any coverage(s) attached to the Covered Person’s Plan.

Exclusions and Limitations

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

1) Suicide, attempted suicide (including drug overdose) self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane;
2) War or any act of war, declared or undeclared;
3) Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, We will refund the unearned pro rata premium upon request;
4) Voluntary, active participation in a riot or insurrection;
5) Medical expenses resulting from a motor vehicle accident in excess of that which is payable under any other valid and collectible insurance;
6) Treatment for an Injury or Sickness resulting from the Covered Person's intoxication or use of illegal drugs or any drugs or medication that is intentionally not taken in the dosage recommended by the manufacturer or for the purpose prescribed by the Covered Person's Physician;
7) Commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal occupation;
8) Eligible Expenses for which the Covered Person would not be responsible in the absence of the Policy;
9) Treatment of acne;
10) Charges which are in excess of Usual, Reasonable and Customary charges;
11) Charges that are incurred outside of the benefit period either prior to coverage commencing or after coverage has terminated.
12) Charges that are not Medically Necessary;
13) Charges provided at no cost to the Covered Person;
14) Expenses incurred for treatment while in Your Home Country which exceed 30 days or $1000;
15) Expenses incurred for an Accident or Sickness after the Benefit Period shown in the Schedule of Benefits or incurred after the termination date of coverage;
16) Injuries paid under Workers’ Compensation, Employer’s liability laws or similar occupational benefits or while engaging in an occupation for monetary gain from sources.
17) Pre-existing conditions; however a Pre-Existing condition will be covered after the Covered Person has been continuously insured for 12 months under the same insurance plan;
18) Treatment of a hernia, including sports hernia, whether or not caused by a Covered Accident;

19) Pregnancy or childbirth, except when conception occurs while covered under the Policy; miscarriage resulting from an accident that exceeds $250-750, elective abortion; elective cesarean section; or any complications of any of these conditions; pregnancy or childbirth or a dependent when dependent child of an Covered Person (except for complications arising there from);

20) Expense incurred for treatment of temporomandibular joint (TMJ) disorders or craniomandibular joint dysfunction and associated myofacial pain;

21) Dental care or treatment other than care of sound natural teeth and gums required on account of injury resulting from an Accident while the Covered Person is covered under the Policy, and rendered within 3 months of the Accident;

22) Eyeglasses, contact lenses, hearing aids braces, appliances, or examinations or prescriptions therefore;

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

24) The cost of the Covered Person’s unused airline ticket for the transportation back to the Covered Person’s Home Country, where an Emergency Medical Evacuation or Repatriation and/or Return of Mortal Remains benefit is provided;

25) Expenses incurred during a Hospital emergency room visit which is not of an emergency nature

26) Travel in or upon:
   (a) A snowmobile;
   (b) A water jet ski
   (c) Any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel;
   (d) Any off-road motorized vehicle not requiring licensing as a motor vehicle;

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

28) Practice or play in any amateur, club, intramural, interscholastic, intercollegiate, professional or semi-professional sports contest or competition;

29) Rest cures or custodial care;

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

31) Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

32) Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
   (a) While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
   (b) While being used for any test or experimental purpose; or
   (c) While piloting, operating, learning to operate or serving as a member of the crew thereof; or
   (d) While traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.
   (e) A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
   (f) An ultra light, hang-gliding, parachuting or bungi-cord jumping;

Except as a fare paying passenger on a regularly scheduled commercial airline.
Claim Provisions

NOTICE OF CLAIM:
Written notice of death, or Injury or Sickness must be given to Us within 30 days after a Covered Loss occurs or begins or as soon as reasonably possible. Notice can be given at Our administrative office as shown on the cover page or to Our authorized licensed agent. Notice should include the Policyholder's name and number and a Covered Person's name and address.

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

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

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

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

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

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

1) it can be shown that it was not possible within reason to submit notice within the 90 day period; and
2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIMELY FILING OF CLAIMS:
All claims for benefits under the Policy must be submitted to Us no more than 90 days from the date of service or date of death.

TIME OF PAYMENT OF CLAIMS:
Benefits due under the Policy for a loss, other than a loss for which the Policy provides installments, will be paid within 30 days after Our receipt of due written proof of such loss.

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

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

PAYMENT OF CLAIMS:
All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of the Policy.

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

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

Any other accrued benefits which are unpaid at a Covered Person's death may, at Our option, be paid either to his beneficiary or to his estate. All other benefits, unless specifically stated otherwise, will be paid to a Covered Person.

DESIGNATION OR CHANGE OF BENEFICIARY:
Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order:

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

4) The estate of the Covered Person.

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

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

PHYSICAL EXAMINATION AND AUTOPSY:
We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

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

1) A request for lump sum payment of the amount overpaid or paid in error or
2) Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error.

RECOVERY OF BENEFITS:
We reserve the right to recover from a Covered Person any benefits We have paid to him for injuries:

(1) Received in a covered Accident; and
(2) Which are covered under:
   a) workers’ compensation or similar statutory remedies available under law; or
   b) Any employer’s liability insurance.

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

“Recovery” means monies paid to the Covered Person through judgment, settlement or otherwise to compensate for all losses caused by the Injury.

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

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

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

ENTIRE CONTRACT CHANGES:

The Policy, the application of the Policyholder, a copy of which is attached to the Policy, endorsements, riders, [and the application or participation agreement with the Participating Organization] and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, the application of any Covered Person, at Our option, may also be made a part of this contract.

All statements made by the Policyholder, Participating Organization, or by a Covered Person are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2-years from the Covered Person's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

No change in the Policy will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE:

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

POLICY TERMINATION:

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

POLICY CANCELATIONS:

Regarding cancellations, we will provide a 14 day free look – the client can get a full refund for any reason within 14 days; if cancellation occurs after 14 days but by 30 days from purchase, we will provide a full refund - if the plan is not approved for waiver but the university (and occurs within 30 days of purchase); we would need you or the student to provide us with University name and copy of the school's email stating the policy was not approved for waiver to honor the cancellation and refund.

CLERICAL ERROR:

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

ASSIGNMENT:

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

INSOLVENCY:

The insolvency, Bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in the Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Covered Persons under the Policy.

NON-PARTICIPATING:

The Policy is non-participating. It does not share in the Company's profits or surplus earnings.

WAIVER:

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

PRE-AUTHORIZATION:
Pre-authorizations are subject to certification by the Plan Administrator. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. Certain medical procedures or treatments will require a request form to be received by the Company or the Company’s authorized representative. This must be received a minimum of 5 business days prior to the scheduled procedure date if the procedure is elective, or within 48 hours after the initial admission, if the admission is due to an emergency. Approval from the Company must be given prior to the commencement of the proposed medical treatment. Failure to comply with prior authorization procedures will result in a 20% reduced benefit penalty, provided that the care is determined to be a procedure that would have been approved by the Plan Administrator. If upon review of medical records, it is determined to be a medical procedure which would not have been approved, the entire claim and all related charges will be denied. Pre-authorization is based on information provided to the Company at the time of request, and does not guarantee payment of benefits nor verify eligibility. Payment for services is subject to all terms, conditions, limitations and exclusions related to the member’s eligibility and subsequent medical review. Regardless of pre-authorization status, medical decisions concerning a course of treatment are solely between the doctor and you.

These services require pre-authorization:

1) Any hospitalization
2) Emergency Treatment, as practical
3) Outpatient or Ambulatory Surgery;
4) Outpatient Treatments

ELIGIBILITY VERIFICATION, BENEFIT VERIFICATION, AND COVERAGE QUESTIONS:

GBG Assist 24-Hour Customer Service
U.S./Canada Toll-free: 1.866.914.5333
Worldwide Collect: 1.905.669.4920
Email: GBGAssist@gbg.com

PROVIDER INFORMATION:

www.gbg.com
Go to Provider Directory
Enter your country and postal code or provider’s name to locate a Provider.

CLAIMS SUBMISSION, STATUS OR APPEALS:

To submit claims online send to: www.gbg.com, or mail to:
Global Benefits Group, Inc.
International Claims Service/ICS
26000 Towne Center Drive, Suite 130
Foothill Ranch, CA 92610 USA

• To ensure appropriate processing, always provide the hospital or doctor with a copy of your ID card so they can bill us for the services provided to you when hospitalized or receiving other emergency treatments. Your ID card shows your member ID and will allow the Provider to verify your benefits in our system. Failure to give the correct information to the provider could result in bills getting sent to you for these services, instead of the insurance company.

• In the case of Preventive Care, as outlined in the Schedule of Benefits, you are only required to pay your deductible and the cost for any services which may not be covered under your policy. However, if you are required to pay for services in full, or for minor expenses associated with minor medical emergencies (less than $500), you will need to provide the necessary documentation for reimbursement: a. Signed medical statement which includes medical coding for service performed by the service provider;
   b. Proof of payment (receipts) and
   c. Copy of your ID card.
   If you get a bill from a provider, call them to make sure they have your insurance information. Failure to contact them with your information will delay the processing of your claim and could result in you being solely responsible for the charges.

• All claims, regardless of submission date, must be received in our office within 90 days of treatment or they will be denied. Initial treatment must occur within 90 days of the Accident or Sickness.

• Once a claim has been reviewed, additional documentation may be required for processing. This request may be made in writing or electronically to the address/e-mail on file. Please make sure your address/e-mail is current in our database.

• To update or check your address on-file, log on our website www.gbg.com

• After a claim has been processed your copy of the EOB information will be available electronically and the provide will also receive an explanation of benefits (EOB). This explanation has a claim number, date of service, paid date, amount paid, amount applied to your deductible and an explanation as to why/how the claim was processed. The EOB will also state if you owe the provider anything for the
service. If there is a reimbursement to you, a check will be attached, and you may review your EOB electronically. If you get a bill from a provider, you should check the website for an electronic copy of the EOB. If it is not available within 60 days please contact us at the number above for claim status.

- If a claim is denied you will receive a written explanation on the EOB. If you feel the decision is wrong, you have the right to appeal the decision which must be done in writing within 4 months of receiving the EOB electronically. Complete and submit the online Claims Appeal Form at www.gbg.com or download the form and submit to: claims@gbg.com
Intentionally left blank
Global Benefits Group offers worldwide expertise, 
Products and services unbound by geographic constrains.

Any Country.

Any Nationality.

GBG Corporate Headquarters
Southern California, USA