TIECARE INTERNATIONAL

INTERNATIONAL STUDENT INDIVIDUAL HEALTH POLICY

Life BULSTRAD VIENNA INSURANCE GROUP

TieCare International is the educational division of GBG Insurance Without Borders℠

Global Student Freedom

TieCare International is the educational division of

GBG

Insurance Without Borders℠

'Welcome to the Bulstrad Life Vienna Insurance Group and Global Benefits Group (GBG) cooperation. GBG is the official administrative Partner of Bulstrad Life Vienna Insurance Group. This is a partnership which provides the best service you could receive in your travel! This is a short-term medical Policy intended to provide Accident and Illness coverage while you are temporarily away from your Home Country and studying abroad. It is not intended to care for general medical conditions or pre-existing medical conditions and is subject to the limits in the Schedule 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 Drugs, 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. provides full reimbursement of eligible medical expenses after a Co-Payment***. 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 Drugs may be obtained from any CVS/Caremark pharmacy***. Present your Medical Identification card to the pharmacist and a discount will be applied. Payment is due at the time of purchase. Follow the claims filing procedures for reimbursement per the benefits shown under the Schedule of Benefits. See the section titled, "How to File a Claim" for instructions on reimbursement.

If you are studying in a country other than the United States, GBG Assist is available to guide you through the process of obtaining medical care in a foreign country.

How You Can Reach Us

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

Worldwide Collect	+1.905.669.4920
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 travel.

Sincerely,

Bob Dubrish

Chief Executive Officer
Global Benefits Group

THANK YOU FOR SELECTING

BULSTRAD LIFE VIENNA INSURANCE GROUP STUDENT HEALTH INSURANCE

Global Student Freedom

Table of Contents

Schedule of Benefits

This Schedule of Benefits and Policy Face Page forms part of the health insurance Policy and is a summary outline of the benefits payable under the Policy. All benefits described are subject to the definitions, limitations, exclusions, and provisions of the Policy Face Page and the Schedule of Benefits. All currency amounts are shown in EUR.

The following benefits are per person per Policy Period and subject to the Plan Participant's Policy Period Deductible. After satisfaction of the Policy Period Deductible, Insurer will pay the eligible benefits set forth in this Schedule at the Allowable Charge, which is defined as Usual, Customary, and Reasonable (UCR). This is the lower of: a) the Provider's usual charge for furnishing the treatment, service or supply; or b) the charge determined by the Insurer to be the general rate charged by the others who render or furnish such treatments, services or supplies to persons who reside in the same country and whose Injury or Illness is comparable in nature and severity.

Benefits will be paid on a Usual, Customary, and Reasonable basis, subject to Policy exclusions, limitations and conditions, for the charges listed, if they are; incurred as a result of Illness or Accidental bodily injury, under the care of a Physician, Medically Necessary; ordered by a Physician; and delivered in an appropriate medical setting.

GENERAL FEATURES AND PLAN SPECIFICATIONS	
U.S. Provider Network	First Health
Annual Maximum	EUR 150,000 per Injury/Illness to an overall Annual Maximum of EUR 500,000
Lifetime Maximum	Unlimited
Plan Coinsurance	100% UCR 60% if an Out-of-Network Provider in the U.S. is used
Overall Deductible	EUR100 per Injury/Illness EUR 45 per Injury Illness at Student Health Center
Office Visit Co-payment, including Student Health Center	None
Emergency Room Deductible (waived if admitted)	EUR 250 per Occurrence
Pre-Existing Conditions	Covered after 180 days
Home Country Coverage	EUR 1,000 per Policy Period
Area of Coverage	Worldwide
HOSPITALIZATION AND INPATIENT BENEFITS	
Room and Board (semi-private room)	100% UCR up to EUR 1,250 per day 30 Days Maximum per Policy Period
Intensive Care / Cardiac Care	100% UCR up to EUR 1,750 per day 8 Days Maximum per Policy Period
Inpatient Consultation (Physician or Specialist)	100% UCR up to EUR 400 per Confinement
Hospital Miscellaneous Expenses	100% UCR up to EUR 500 per day 30 Days Maximum per Policy Period
Pre-Admission Testing	100% UCR up to EUR 900 per Confinement

HOPITALIZATION AND INPATIENT BENEFITS (Continued)	
Surgical Expense	
• Surgeon's Fees • Inpatient and Outpatient	100% UCR EUR 3,000 Maximum per Policy Period
Assistant Surgeon and Anesthesiologist	25% of Surgeon's payable benefit
Ambulance Services	
Emergency Local Ground Ambulance	100% UCR EUR 400 Maximum per Policy Period
Chemotherapy, Radiotherapy	
• Coverage for chemotherapy and radiotherapy • Inpatient and Outpatient	100% UCR EUR 1,000 Maximum per Policy Period
Mental Health	
Inpatient benefit to treat a covered diagnosis	80% UCR 30 Days Maximum per Policy Period
OUTPATIENT BENEFITS	
Outpatient or Ambulatory Surgery	
• Outpatient or Ambulatory Surgery • Anesthesia, Drugs, Medications	100% UCR EUR 1,000 Maximum per Policy Period
Outpatient Physician Visit	
• General Practitioner or Specialist • Urgent Care Center	100% UCR, up to EUR 50 Maximum Benefit per visit 30 visit Maximum per Policy Period
Prescription Drugs	
• Up to 31-day supply per prescription • Includes Contraceptives	100% UCR EUR 100 Maximum per Policy Period
Diabetic Medical Supplies	
Includes Insulin Pumps and associated supplies	Covered Under Prescription Drug Benefit
Emergency Room	
Deductible waived if admitted	80% UCR after Deductible
Therapeutic Services, Physiotherapy	
Physical Therapy, Chiropractic, Occupational Therapy, Vocational Speech Therapy, only when prescribed by a Physician	100% UCR up to EUR 35 per visit 12 visit Maximum Benefit per Policy Period per injury or illness
Mental Health	
Outpatient Treatment	80% UCR 30 Visit Maximum per Policy Period, EUR 3,000 Maximum Benefit per Policy Period

OUTPATIENT BENEFITS (Continued)	
Diagnostic Tests and Procedures	
• X-Ray and Laboratory • MRI, PET and CT Scans** (Additional EUR350 Maximum per Policy Period for these scans) • Inpatient and Outpatient	100% UCR EUR 500** Maximum per Policy Period
Maternity	
Normal delivery including prenatal care, postnatal care and complications of pregnancy.	EUR 5,000 Maximum Benefit for normal delivery, EUR 7,500 for C-section delivery
Alcohol and Drug Abuse	
• Rehabilitative treatment only • Inpatient or Outpatient	Included under Hospitalization/Inpatient Benefits and Outpatient Physician Benefits
Durable Medical Equipment	
Reimbursement of rental up to purchase price	100% UCR EUR 1,000 Maximum Benefit per Policy Period
Emergency Dental Care	
Limited to accidental injury of sound natural teeth sustained while covered under the policy	100% UCR EUR 500 Maximum Benefit per Tooth

ADDITIONAL BENEFITS	
Medical Evacuation and Repatriation	EUR 60,000 Maximum Benefit per Policy Period
Return of Mortal Remains	EUR 50,000 Maximum Benefit
Accidental Death and Dismemberment	EUR 10,000 Maximum Benefit

Accidental Death and Dismemberment

Accidental Death and Dismemberment	
Principal Sum for Primary Plan Participant	EUR 10,000
Time Period for Loss	90 days
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%
Quadriplegia	100%
Paraplegia (total paralysis of both lower limbs)	75%
Hemiplegia (total paralysis of upper and lower limbs of one side of body)	50%
Uniplegia (total paralysis of one limb)	25%

General Provisions

The **Policyholder** is the covered person whose name is shown on the Policy Face Page as "Policyholder".

Insurer (Bulstrad Life Vienna Insurance Group), the Second party, whose name is shown on the Policy Face Page as "Insurer", hereinafter shall be referred to, sometimes collectively, as the "Insurer", "We" "Us", or "Company".

The declarations of the Policyholder and eligible Dependents in the application serve as the basis for the Policy. If any information is incorrect or incomplete, or if any information has been omitted, the Policy may be rescinded, cancelled or modified. Any references in this Policy to the Policyholder and his Dependents that are expressed in the masculine gender shall be interpreted as including the feminine gender whenever appropriate.

Entire Policy and Changes

This Policy, Policy Face Page, Schedule of Benefits, the Policyholder application, and any amendments or endorsements (if any) comprise the entire Contract between the parties.

No change may be made to this Policy unless it is approved by an Officer of the Insurer. A change will be valid only if made by a Policy Endorsement signed by an Officer of the Insurer, or an amendment of the Policy in its entirety issued by the Insurer. No agent or other person may change this Policy or waiver any of its provisions.

Eligibility

Eligible Classes

All international, full-time students enrolled in and attending a recognized higher education institute 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.

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 Insurer's only obligation is to refund any Premium paid for that person.

Persons Eligible

Insured Persons under the Policy are those persons described as an Eligible Class.

- Student minimum age is 12 years and maximum is 64 years,
- Student must be travelling outside their Home Country.

Students who are United States citizens living in the United States are not eligible for coverage.

Eligible Dependents

Coverage under this Policy can be extended to the following family members who are travelling with the student. Insured Dependents may include:

- The spouse or domestic partner,
- Dependent children up to age 19, if single. Dependent children include the Policyholder's natural children, legally adopted children, and step children.

Dependents who are United States citizens living in the United States are not eligible for coverage.

Application and Effective Date

The Policyholder's coverage becomes effective on the later of; the effective date shown on the Policy Face Page or when they depart for their international destination at the start of the trip. Coverage under the plan ends on the earlier of;

- When the Insured Person returns to their Home Country at the completion of their trip, or
- On the expiration date of the Policy Period. However, if an Policyholder's return is delayed due to unforeseeable circumstances beyond their control, the Policy Period will be extended until such trip can be completed, but no later than seven days from the original Policy Period expiration, or

- If medical evacuation was necessary, upon the Policyholder's evacuation to the Home Country.
- Termination of coverage of the Policyholder also terminates coverage for Dependents.

Addition of a Newborn Baby or Legally Adopted Child

Coverage under this Policy is available under the following terms:

- A health application must be submitted detailing the medical history of the child,
- A copy of the birth certificate or legal adoption papers is required,
- Coverage is not guaranteed and subject to underwriting approval. If approved, coverage will become effective as of the date of application, and for a period of 12 months pre-existing conditions will not be covered.

Reduced-Course Load

If the Policyholder withdraws from classes within the first 31 days due to medical necessity that prevents the Policyholder from attending classes, the Policyholder will be allowed to keep the coverage in effect for the remainder of the quarter or semester in which the medical problem occurred and for which Premium has been paid. In no event will additional extensions be available, regardless of whether it is a vacation, medical reduced-course load, and/or a 60-day extended period of coverage prior to returning to their Home Country.

Terms and Conditions

Pre-Existing Conditions

A Pre-Existing Condition is defined as any illness or injury, physical or mental, for which an Insured Person received any diagnosis, medical advice or treatment, or had taken any Prescription Drug, or where distinct symptoms were evident prior to the effective date.

Refer to the Schedule of Benefits to determine if coverage for Pre-Existing Conditions is included, and any waiting period that may be applied.

Premium Payment

All coverage under this Policy is subject to the timely payment of Premium, which must be made payable to the Insurer. Payment must be in the currency approved by the Insurer. Any other forms of currency shall not be accepted and will be considered as nonpayment of Premium unless otherwise agreed by the Insurer. The Policy and rates shall be guaranteed for the Policy Period and are continually subject to the terms in force. All Premiums are payable before coverage under this Policy is provided.

Policy and Rate Modifications

The Policy term begins on the Effective Date of the Policy as shown in the Policy Face Page and ends at midnight on the date shown, but no longer than 364 days. The Policy is not subject to guaranteed issuance or renewal.

The Insurer has the right to modify Premium, or rate basis, on any Anniversary Date, unless there is a change in the residence location of the Policyholder. The Insurer must notify the Policyholder of the change at least 30 days before the Insurer makes the change.

Other Premium Changes

Premium changes due to the following will occur automatically and will be charged from the date the change occurs:
An increase or decrease in benefits provided under the Policy; or

- Addition of a new Insured Person; or
- Termination of an Insured Person;

Any such change will be prorated to the Premium payment period of the Insured Person and reflected on the Policyholder's next billing statement.

Duration of Coverage

Benefits are paid to the extent that an Insured Person 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 Insured Person or their last date of coverage as listed in the Policy Face Page.

Compliance with the Policy Terms

Our liability under this Policy will be conditional upon each Insured Person complying with its terms and conditions.

Change of Risk

The Policyholder must inform the Company as soon as reasonably possible, of any changes related to the Insured Person (such as change of address, occupation or marital status) or of any other material changes that affect information given in connection with the application for coverage under this Policy. The Company reserves the right to alter the Policy terms or cancel coverage for an Insured Person following a change of risk.

Cancellation

The Company reserves the right to cancel any Policy as described below:

- This Policy will be canceled automatically upon nonpayment of the Premium, although the Company may at their discretion reinstate the coverage if the Premium is subsequently paid.
- If any Premium due from the Policyholder remains unpaid, the Company may in addition defer or cancel payment of all or any claims for expenditures incurred during the period it remains unpaid.
- While the Company shall not cancel this Policy because of eligible claims made by any Insured Person, it may at any time terminate an Insured Person or subject his coverage to different terms if the Insured Person has at any time:
  - Misled the Company by misstatement or concealment;
  - Knowingly claimed benefits for any purpose other than are provided for under this Policy;
  - Agreed to any attempt by a third party to obtain an unreasonable advantage to the Insurer's detriment;
  - Failed to observe the terms and conditions of this Policy, or failed to act with utmost good faith.
- The Insurer retains the right to cancel, non-renew or modify a Policy on a Class basis as defined in this Policy, and the Insurer will offer the closest equivalent coverage possible to the Policyholder. No individual Policyholder shall be independently penalized by cancellation or modification of the Policy due solely to a poor claim record.
- If the Company does cancel this Policy, they shall give 30 days' notice. The Company will refund the unearned portion of the Premium minus administrative charges and Policy fees.

If the Policyholder cancels the Policy after it has been issued, reinstated or renewed, the Insurer will not refund the unearned portion of the Premium.

Fraudulent/Unfounded Claims

If any claim under this Policy 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.

Jurisdiction

This Policy is not designed to cover United States residents and citizens. As such, the insurance is not subject to, and is not administered as a PPACA (Patient Protection and Affordable Care Act) insurance plan.

Privacy

The confidentiality of information is of paramount concern to the GBG companies. GBG complies with Data Protection Legislation and Medical Confidentiality Guidelines. Information submitted to GBG over our website is normally unprotected until it reaches Us. We do share information, but only as it pertains to the administration of your health care benefits.

Settlement of Claims

All paid claims will be settled in the same currency as the Premium currency. If the Insured Person paid for treatment, or receives a bill for covered services in a currency other than Premium currency, including bills sent directly to the Company or its Claims Administrator, such payments and bills shall be converted to Premium currency at the exchange rate in effect at the time such service was rendered. The exchange rate will be determined by the Insurer acting reasonably.

Waiver

Waiver by the Company of any term or condition of this Policy will not prevent Us from relying on such term or condition thereafter.

Denial of Liability

The Insurer is not responsible for the quality of care received from any institution or individual. This Policy does not give the Insured Person any claim, right or cause of action against Insurer based on an act of omission or commission of a Hospital, Physician or other Provider of care or service.

Pre-Authorization Requirements and Procedures

Certain designated services require Pre-Authorization, and Insured Persons are required to follow the procedures outlined below.

Pre-Authorization is a process by which an Insured Person obtains approval for certain non-emergency, medical procedures or treatments prior to the commencement of the proposed medical treatment. This requires that the Insured Person submit a completed Pre-Authorization Request form to GBG Assist **a minimum of 5 business days prior** to the scheduled procedure or treatment date. GBG Assist will review the matter and respond to the Insured Person. To assure full reimbursement for covered services, written approval from GBG Assist must be received by the Insured Person prior to the commencement of the proposed medical treatment.

The following services require Pre-Authorization:

- Hospitalization
- Outpatient Surgery
- Home Health Benefits including Private Duty Nursing, Skilled Nursing, and Visiting Nurse
- Air Ambulance – Air Ambulance service will be coordinated by Insurer's Air Ambulance Provider
- Specialty Treatments and Highly Specialized drugs
- Alcohol and Drug abuse treatment
- Any condition, including cancer treatment or any Chronic Condition, or outpatient services which do not meet the above criteria, but are expected to accumulate over EUR 10,000 of medical treatment per Policy Period.

The Insured Person must obtain a letter of authorization, prior to the performance of those services. For both Pre-Authorization requests and Network information, customer service representatives are available 24 hours a day, every day. Network facilities can also be found at www.gbg.com.

Please note: some treatment requests may require longer than 5 days for the review process to be completed.

Medical Emergency Authorizations must be received within 48 hours of the Admission or procedure. In instances of medical emergency, the Insured Person should go to the nearest Hospital or Provider for assistance even if that Hospital or Provider is not part of the Preferred Provider Network.

Failure to obtain Pre-Authorization will result in a 40% reduction in payment of Covered Expenses. Any such penalty will apply to the entire episode of care. If treatment would not have been approved by the Pre-Authorization process, all related claims will be denied.

Notwithstanding the requirement to pre-authorize:

- Pre-Authorization approval does not guarantee payment of a claim in full, as Deductibles, charges in excess of Usual, Customary and Reasonable and out of pocket charges may apply.
- Benefits payable under the Policy are still subject to Eligibility at the time charges are actually incurred, and to all other terms, limitations, and exclusions of the Policy.

Preferred Provider Network

The Company maintains a Preferred Provider Network. For information on the Providers and facilities within the Preferred Provider Network, consult GBG Assist at the number on the Medical Identification Card or www.gbg.com. **Please refer to Pre-Authorization Requirements and Procedures**.

United States only:

- **Preferred Provider In-Network:** This tier consists of all Providers as well as other preferred Providers designated by the Company and listed on the website. In-Network Providers have agreed to accept a negotiated discount for services. 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 Insured Person. The Insurer reimburses such Providers up to a Usual, Customary and Reasonable amount as determined by the Insurer. The Provider may bill the Insured Person the difference between the amounts reimbursed by the Insurer and the Provider's billed charge. Additionally, the Insured Person will pay a Coinsurance amount that is higher than if an In-Network Provider were used.

All other Countries: The Insured Person may utilize any licensed Provider. However, we suggest the Insured Person contact GBG Assist to locate a Provider with a direct billing arrangement with the Insurer.

The Company retains the right to limit or prohibit the use of Providers which significantly exceed Usual, Customary and Reasonable charges.

Health Care Coverage and Benefits

Deductible

Deductible is the first dollar amount paid by each of the Insured Persons of the Allowable Charges for eligible medical treatment expenses during each Policy Period before the Policy benefits are applied Deductibles are shown on the Medical Identification Card and the Schedule of Benefits.

Application of Deductible

When claims are presented to Insurer, the Allowable Charges will be applied towards the Deductible, and if applicable will then be calculated and reimbursed at the percentage listed on the Schedule of Benefits. Once the Deductible has been satisfied, all allowable expenses will be paid at Usual, Customary, and Reasonable charge up to the listed maximum amounts outlined in the Schedule of Benefits.

Annual and Lifetime Maximum

Certain payment of Benefits are subject to an Annual or Lifetime Maximum per individual Insured Person as indicated in the Schedule of Benefits, as long as the Policy remains in force. The Annual and Lifetime Maximum includes all Maximum Benefits specified in this Policy, including those specified in the Schedule of Benefits, Policy Face Page and in any Policy endorsements or riders.

Scope of Coverage

The Policy covers the Insured Persons for Allowable Charges for covered medical services provided in the areas of coverage selected in the Policy Face Page, including hospitalization, surgery, out-patient services, medical treatment and medical supplies incurred while such Insured Person is enrolled under the Policy. Such services must be recommended or approved by a licensed medical professional. They must also be essential and Medically Necessary, in the Insurer's judgment, for the treatment of an Insured Person's injury or Illness for which insurance is provided under the Policy.

Areas of Coverage

The Policy is written on a Worldwide basis.

Schedule of Benefits and Policy Face Page

All benefits of this Policy are payable in accordance with the Schedule of Benefits and the Policy Face Page in effect at the time the services are rendered. The Schedule of Benefits and the Policy Face Page contains payment levels, benefit limitations, Maximum Benefits and other applicable information. Receipt of the current Schedule of Benefits and the Policy Face Page shall constitute delivery to the Policyholder. Payment of Benefits as set forth in the Schedule of Benefits is subject to the Policy Year Deductible, Co-payments and any other limitations set forth in the Policy, unless otherwise noted.

Inpatient Hospital Benefits

Inpatient Services

Hospitalization services include, but are not limited to, semi-private room and board , general nursing care, services and supplies as Medically Necessary and approved and covered by the Policy and meals and special diets (only for the patient). All charges in excess of the allowable semi-private rate are the responsibility of the Insured Person.

Benefits will be provided based on the Allowable Charge for Medically Necessary Intensive Care services.

If Medically Necessary for the diagnosis and treatment of the Illness or injury for which an Insured Person is Hospitalized, the following ancillary services are also covered:

- Use of operation room and recovery room;
- All medicines listed in the U.S. Pharmacopoeia or National Formulary;
- Blood transfusions, blood plasma, blood plasma expanders, and all related testing, components, equipment and services;
- Surgical dressings;
- Laboratory testing;
- Durable Medical Equipment;
- Diagnostic x-ray examinations; including advanced diagnostics (CT, MRI, & PET);
- Radiation therapy rendered by a radiologist for proven malignancy or neoplastic diseases;
- Respiratory therapy rendered by a Physician or registered respiratory therapist;
- Chemotherapy rendered by a Physician or Nurse under the direction of a Physician;
- Physical and Occupational therapy (if covered) must be rendered by a Physician or registered physical or occupational therapist and relate specifically to the Physician's written treatment plan. Therapy must:
  - Produce significant improvement in the Insured Person's condition in a reasonable and predictable period of time, and
  - Be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed only by a registered physical or occupational therapist, or
  - Be necessary to the establishment of an effective maintenance program. Maintenance itself is not covered.

Surgical and Medical Benefits

Surgical Services

Insurer will provide benefits for covered surgical services received in a Hospital, a Physician's office or other approved facility. Surgical services include operative and cutting-procedures, treatment of fractures and dislocations and obstetrical delivery. When Medically Necessary, assistant surgical fees will be paid.

Anesthesia Services

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

Inpatient Medical Services

Insurer will reimburse one Physician visit per day while the Insured Person 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, Insurer may elect to pay more than one visit of different Physicians on the same day if the Physicians are of different specialties. When lengthy, prolonged or repeated Inpatient visits by the

Physician are necessary because of a Critical Condition, payment for such intensive medical services is based on each individual case. Insurer will require submission of records and other documentation of the Medical Necessity for the intensive services. Inpatient medical services are payable in accordance with the current Schedule of Benefits.

Inpatient Care Duration/ Inpatient Extended Care

Inpatient Hospital Confinements, where an overnight accommodation, ward, or bed fee is charged, will only be covered for as long as the patient meets the following criteria:

- The patient's medical status continues to require either acute or sub-acute levels of curative medical treatment, skilled nursing, physical therapy, or Rehabilitation services. GBG Assist is responsible for this determination of the patient's medical status.

Inpatient Hospital Confinements primarily for purposes of receiving non-acute, long term Custodial Care, chronic maintenance care, or assistance with Activities of Daily Living (ADL), or where the procedure could have been done in an Outpatient setting are not eligible expenses.

Reconstructive surgery as a result of an accident or illness will be covered as long as it is determined that it is medically necessary.

Emergency Ground Ambulance and Air Ambulance Services

Benefits are provided for Medically Necessary emergency ground ambulance and air ambulance transportation to the nearest Hospital able to provide the required level of care and are payable in accordance with the current Schedule of Benefits. The use of ambulance services for the convenience of the Insured Person, which are not Medically Necessary, will not be considered a covered service.

Outpatient Services

When an Insured Person is treated as an outpatient of a Hospital or other approved facility, benefits will be paid for facility charges and ancillary services according to the current Schedule of Benefits for the following:

- Treatment of accidental injury within 48 hours of the accident;
- Minor surgical procedures;
- Medically Necessary covered emergency services, as defined herein.

Outpatient or Ambulatory Surgery Benefit

We will pay Day Surgery Miscellaneous benefits for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs or medicine; therapeutic services; and supplies, on an outpatient basis. This includes endoscopy services as well as Advanced Diagnostics including Hi-tech scans (CT,MRI, and PET).

Outpatient Physician Visits

Insurer provides benefits for medical visits to a Physician, in the Physician's office, if Medically Necessary. Services for routine physical examinations, including related diagnostic services and routine foot care are not covered, except as specifically provided for in this Policy. All Outpatient Physicians visits are payable in accordance with the current Schedule of Benefits.

Prescription Drugs

Prescription Drugs 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 and/or Investigational drugs, or supplies, even when recommended by a Physician, do not qualify as Prescription Drugs. Any drug 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 be covered, even if a Physician prescribes it.

Highly specialized drugs for specific uses may be covered but must be Pre-Authorized and coordinated in advance by GBG Assist. These drugs include but are not limited to the following; Interferon beta-1-a, PEGylated Interferon alfa 2a, Alfa, Interferon beta-1-b, Etanercept, adalimumab, Bevacizumab, Cyclosporine A, Azathioprine, and Rituximab.

Refer to Schedule of Benefits for the Maximum Benefit.

Diabetic Medical Supplies

Insurer provides benefits for certain diabetic supplies including Insulin Pumps and associated supplies.

Emergency Room Benefit

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

Therapeutic Services, Physiotherapy

Insurer will provide benefits for Medically Necessary therapeutic services rendered to an Insured Person as an Outpatient of a Hospital, Provider's office, or approved independent facility. Benefits for facility and professional services for Therapeutic Services are payable in accordance with the current Schedule of Benefits. 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. Services must either:

- Produce significant improvement in the Insured Person's condition in a reasonable and predictable period of time; and
- Be of such a level of complexity and sophistication, and/or 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.

Mental Health Benefit

Benefits are provided for psychotherapeutic treatment and psychiatric counseling and treatment for an approved psychiatric diagnosis and are payable as follows and in accordance with the current Schedule of Benefits:

- Inpatient mental health
- Outpatient mental health

The following is set forth in the Schedule of Benefits:

1. Benefits are for both Inpatient mental health treatment in Hospital or approved facility and for Outpatient mental health treatment. A Physician or a licensed clinical psychologist must provide all mental health care services.
2. Services of a clinical psychologist must be rendered in the Provider's office or in the Outpatient department of a Hospital.
3. Services Include treatment for bulimia, anorexia, bereavement, non-medical causes of insomnia, attention deficit disorder (ADD), and ADHD when approved by GBG Assist.
4. The following services are excluded:
    - Aptitude testing, educational testing and services;
    - Services for conditions not determined by Insurer as to be emotional or personality Illnesses;
    - Psychiatric services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation;
    - Services for mental disorders or Illness which are not amenable to favorable modification;
    - Marriage and family counseling.

Maternity Related Services

The following maternity benefits are covered as outlined in the Schedule of Benefits and are applicable to any condition related to pregnancy, including but not limited to childbirth, prenatal, miscarriage, premature birth, and complications of the pregnancy where the actual date of delivery is at least 10 months from the effective date. No maternity related treatment for the mother or newborn is covered during this period. The following benefits are only available to the Policyholder or spouse. Maternity benefits for a Dependent daughter are not covered. Fertility/infertility services, tests, treatments, drugs and/or procedures, complications of that pregnancy, delivery and postpartum care are excluded from coverage.

- Pre-natal vitamins are covered during the term of the pregnancy only, if prescribed by a Physician;
- Two ultrasounds will be allowed per pregnancy. In the event of a high-risk pregnancy or complications, additional ultrasounds will be considered with a letter of Medical Necessity from the Physician.
- **Obstetrical Services:** Services are covered as set forth in the Schedule of Benefits and are limited to the following:

a. Hospital services rendered in a licensed Hospital or approved birthing center (including anesthesia, delivery, Medically Necessary C-section, pre-natal and post-natal care) for any condition related to pregnancy, including but not limited to childbirth and miscarriage. Elective C-sections are not covered.
b. Obstetrical services (including prenatal, delivery and post-natal care) and anesthesia services by Physicians.

- **Newborn Infant Care Services:** Hospital nursery services and medical care provided by the attending Physician for newborn infants in the Hospital are covered if notification is received by the Insurer within 14 days of birth for enrollment as an Insured Person. Newborn infant's coverage without notification during the first 14 days will not exceed EUR 5,000 maximum. Charges for Hospital nursery services and professional services for the newborn Infant are covered separately from the mother's maternity benefits and are subject to the satisfaction of the Policy Year Deductible and Coinsurance amounts in accordance with the Policy and the current Schedule of Benefits.

Health complications as a result of pregnancy are subject to the Annual Maximum and not the Maximum Benefit for Maternity.

Alcohol and Drug Abuse Benefit

Outpatient and Inpatient rehabilitation treatment for Alcohol and Drug Abuse is covered under this Policy. Outpatient treatment and Physician services include charges for services rendered in a Physician's office or by an Outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the 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 Insured Person needs to continue such treatment.

All treatment programs must be Pre-authorized and are payable in accordance with the Schedule of Benefits.

Durable Medical Equipment (DME)

Insurer provides benefits for prosthetic devices (artificial devices replacing body parts), orthopedic braces and Durable Medical Equipment (including wheelchairs and Hospital beds). The Policy will pay the Reasonable and Customary charges for Artificial Devices listed, provided such DME is:

1. Prescribed by a Physician, and
2. Customarily and generally useful to a person only during an Illness or injury, and
3. Determined by Insurer to be Medically Necessary and appropriate.

Insurer will allow for two breast prosthesis for cancer patients who have a mastectomy while covered under this Policy. Bras will be a covered expense.

Allowable rental fee of the Durable Medical Equipment must not exceed the purchase price. Benefits are payable in accordance with the current Schedule of Benefits.

Charges for repairs or replacement of artificial devices or other Durable Medical Equipment originally obtained under this Policy will be paid at 50% of the allowable Usual, Reasonable and Customary amount.

Durable Medical Equipment **does not** include: motor driven wheelchairs or beds; more wheels; comfort items such as telephone arms and over bed tables; items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners); disposable supplies; exercise bicycles; sun or heat lamps; heating pads; bidets; toilet seats; bathtub seats; sauna baths; elevators; whirlpool baths; exercise equipment; and similar items or the cost of instructions for the use and care of any Durable Medical Equipment. The customizing of any vehicle, bathroom facility, or residential facility is also excluded.

Emergency Dental

Emergency Dental Treatment and restoration of sound natural teeth required as a result of a Covered Accident is included. All treatment must be completed within 120 days of the Accident or before the expiration date of the Policy.

Leisure Sports and Activities

The Policy does not cover injuries resulting from interscholastic, intramural, and club sports.

Hazardous and Extreme Sports and Activities

The Policy does not cover hazardous and extreme sports and activities meaning any activity requiring an increased skill set and higher level of training to safely participate, and that if not properly executed could result in risk of injury or death.

Other Benefits

Medical Evacuation/Repatriation

Utilization of the medical evacuation provision requires the Pre-Authorization by GBG Assist. In the event of an emergency that may require Medical Evacuation, contact GBG Assist in advance in order to approve and arrange such Emergency Medical Air Transportation. If the Insured Person fails to follow these conditions, he or she will be liable for the full costs of any transportation. GBG Assist, on behalf of the Insurer, retains the right to decide the medical facility to which the Insured Person shall be transported. GBG Assist contact information can be located on the Insured Person's Medical Identification Card. The cost of a person accompanying an Insured Person is covered under this Policy.

- Emergency evacuation is only covered if related to a covered condition for which treatment cannot be provided locally and transportation by any other method would result in loss of life or limb. GBG Assist, on behalf of the Insurer, retains the right to decide the medical facility to which the Insured Person shall be transported. Emergency transportation must be provided by a licensed and authorized transportation company to the nearest medical facility. The vehicle or aircraft used must be staffed by medically trained personnel and must be equipped to handle a medical emergency.
- Approved medical evacuations will be to the nearest medical facility capable of providing the necessary medical treatment.
- The Insured Person agrees to hold the Insurer and any company affiliated with the Insurer by way of similar ownership or management, harmless from negligence resulting from such services, or negligence regulating from delays or restrictions on flights caused by the pilot, mechanical problems, or governmental restrictions, or due to operational conditions.
- Within 90 days of the medical evacuation, the return flight for the Insured Person and an accompanying person will be reimbursed up to the cost of an airplane ticket in economy class only to the Insured Person's Home Country.

Medical Repatriation

If an Insured can no longer meet the Eligibility requirements of this Policy due to medical reasons, GBG Assist will make the determination if medical Repatriation to the Home Country is necessary. GBG Assist will coordinate return to the Home Country. If the Insured Person refuses Repatriation, the Policy will be terminated for failure to meet Eligibility requirements.

Return of Mortal Remains

The necessary clearances for the return of an Insured Person's mortal remains by air transport to the Home Country will be coordinated by GBG Assist.

A benefit for either Repatriation of mortal remains or Local Burial is included under this Policy. 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.

Refer to Schedule of Benefits for details.

Accidental Death and Dismemberment Benefits (Policyholder only covered for this benefit)

The Insured 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 the Principal Sum indicated on the Schedule of Benefits. If the Insured Person incurs a covered loss, the Insurer will pay the percentage of the Principal Sum shown in the table. If the Insured 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 Person is entitled. The loss must result within 90 days of the Accident. Your coverage under the Policy must be inforce.

- 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.

Exclusions and Limitations

All services and benefits described below are excluded from coverage or limited under your Policy of Insurance.

1. Claims and costs for medical treatment, occurring before the effective date of coverage (including waiting periods) or after the expiration date of the Policy. This includes any portion of a covered Prescription Drugs to be used after the expiration of the current Policy Period.
2. Services, supplies, or treatment including Prescription Drugs and/or emergency services 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, (b) the Insured Person, a family member or any enterprise owned partially or completely by the aforementioned persons, (c) another insurance company or government, (d) under the direction of public authorities related to epidemics.
3. Services, supplies or treatments, including Prescription Drugs, that are not scientifically or medically recognized for a specific diagnosis, or that is considered as off label use, Experimental or not approved for general use are considered Experimental and/or Investigational and therefore not eligible services.
4. Any services, supplies, treatments including Prescription Drugs and/or emergency air services: (a) not ordered by a Physician, (b) not Medically Necessary, (c) not recommended or approved by a Physician, (d) not rendered under the scope of the Physician's licensing, (e) medical and dental services that do not meet professionally recognized standards or are determined by Insurer to be unnecessary for proper treatment.
5. Telephonic consultations, missed appointments, or "after hours" expenses.
6. Personal comfort and convenience items including but not limited to television, housekeeping services, telephone charges, take home supplies, ambulance services (other than those provided by this Policy), and all other services and supplies that are not Medically Necessary including expenses related to travel and hotel costs incurred for medical or dental care.
7. Health check-ups, inoculations, visits, and tests necessary for administrative purposes (e.g. determining insurability, employment, school or sport related physical examinations, travel etc.).
8. Immunizations.
9. Over-the-counter (OTC) drugs, supplies or medical devices, even if recommended by a Physician, including but not limited to: smoking cessation drugs, appetite suppressant, hair regenerative drugs or products, anti-photo aging drugs, cosmetic and beauty aids, acne and rosacea drugs (including hormones and retin A) for cosmetic purposes, megavitamins, vitamins, (other than pre-natal as described under maternity), sexual enhancement devices, supplements, herbs or drugs, for any reason.
10. Services and supplies related to visual therapy, radial keratotomy procedures, lasik, or eye surgery to correct refractive error or deficiencies, including myopia or presbyopia.
11. Rest cures, Custodial Care, home-like care, assistance with Activities of Daily Living (ADL), milieu therapy for rest and/or observation, whether or not prescribed by a Physician. Any Admission to a nursing home, home for the aged, long term care or Rehabilitation facility, sanatorium, spa, hydro clinic or similar facilities that do not meet the Policy definition of a Hospital. Any Admission, arranged wholly or partly for domestic reasons, where the Hospital effectively becomes or could be treated as the Insured Person's home or permanent abode.
12. Elective and or cosmetic surgery, procedures, treatments, technologies, drugs, devices, items and supplies that are not Medically Necessary treatment of a covered Accidental injury or Illness or disease, and that may only be provided for the purpose of improving, altering, enhancing, or beautification unless required due to the treatment of an injury, deformity, or Illness that compromises functionality and that first occurred while the Insured Person was covered under this Policy. This also includes any surgical treatment for nasal or septal deformity that was not induced by trauma.
13. Any medical complications arising directly or indirectly as a result of a non-authorized elective or cosmetic procedure.
14. Medical expenses resulting from a motor vehicle Accident, and in excess of that which is payable under any other valid and collectible insurance.
15. Sleep studies and other treatments relating to sleep apnea including restless leg syndrome.
16. Weight related treatment: any expense, service or treatment for obesity, weight control, or any form of food supplement. This includes expenses related to or associated with treatment of morbid or non-morbid obesity, including, but not limited to, gastric bypass, gastric balloons, gastric stapling, jejunal ileal bypass, and any other procedures or complications arising there from.
17. Organ transplant and related procedures.

18. Any fertility/infertility services, tests, treatments and/or procedures of any kind, including, but not limited to, fertility/infertility drugs, including drugs to regulate the menstrual cycle/ovulation for family planning purposes, artificial inseminations, in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), surrogate mother and all other procedures and services related to fertility and infertility. Any pregnancy resulting from such treatments, pre-natal care, complications of that pregnancy, delivery and postpartum care are also excluded.
19. Genetic counseling, screening, testing or treatment.
20. Elective abortions: any voluntarily induced termination of pregnancy, unless the mother's life is in imminent danger.
21. Conditions related to sex or gender issues and sexually transmitted diseases. Any expense for gender reassignment, sexual dysfunction including but not limited to impotence, inadequacies, disorders related to sexually transmitted human papillomavirus (HPV), and any other sexually transmitted diseases.
22. Maternity/delivery preparation classes.
23. Circumcisions, unless Medically Necessary and Pre-Authorized.
24. Treatment of any illness or injury arising directly or indirectly from Alcohol or Drug Abuse or addiction. This includes but is not limited to treatment for any illness or injury caused by, contributed to or resulting from the Insured Person's use of alcohol, illegal drugs, or any drugs or medicines that are not taken in the dosage or for the purpose prescribed by the Insured Person's Physician.
25. Treatment for any conditions as a result of self-inflicted Illnesses or injuries, suicide or attempted suicide, while sane or insane, or emergency air services for the same.
26. Injuries and/or Illnesses resulting or arising from or occurring during the commission or perpetration of a violation of law by an Insured Person.
27. Eyeglasses, contact lenses or sunglasses.
28. Prosthesis and corrective devices which are not medically required intra-operatively or equivalent appliances; except prosthesis or Durable Medical Equipment used as an integral part of treatment prescribed by a Physician, meeting the covered categories of Durable Medical Equipment or prosthesis and approved in advance by GBG Assist.
29. Routine podiatry or other foot treatment not resulting from an Illness or injury. Orthopedic shoes or other supportive devices for the feet, such as, but not limited to, arch supports and orthotic devices or any other preventative services and supplies; any devices resulting from the diagnosis of weak, strained, unstable or flat feet or fallen arches, or any tarsalgaia, metatarsalgia or specified lesions of the feet, such as corns, calluses, and hyperkeratosis, toenails or bunions, pedicures, special shoes and inserts of any form or type.
30. Growth hormones, unless Medically Necessary and preauthorized by GBG Assist. This includes treatment by a bone growth stimulator, bone growth stimulation or treatment related to growth hormone, regardless of the reason for prescription.
31. Health care services associated with conditions as a result of travel, following the receipt of advice against travel because of health reasons from any health care Provider.
32. Hearing aids, hearing devices and bone anchored hearing aids.
33. Exceptional risks: (a) treatment as a consequence of injury sustained while participating in intercollegiate, interscholastic, intramural, or club sports or training for semi-professional or professional sports, or hazardous/extreme sports; (b) treatment as a consequence of injury sustained while participating in, or training for, or as a consequence of war (declared or not), acts of Terrorism, acts of foreign enemy hostilities, civil war, rebellion, revolution or insurrection; (c) chemical contamination; (d) contamination by radioactivity from any nuclear material or from the combustion of nuclear fuel; (e) 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.
34. Treatment of Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by and/or related to the HIV Virus.
35. Except for Accidental injury to sound, natural teeth, dental care is excluded from coverage. Treatment, services or supplies related to (a) the teeth; and (b) the gums other than tumors; and (c) any other associated structures; (d) the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces, or other mechanical aids; and (e) dental implants, regardless of cause.
36. Treatment services or supplies as the result of prognathism, retrognathism, microtrognathism, or any treatment, services, or supplies to reposition the maxilla (upper jaw), mandible (lower jaw), or both maxilla and mandible. This includes treatment for (TMJD) or Temporomandibular Malocclusion Joint Disorders.
37. This Policy will not cover any services received by any parties or in any countries where otherwise prohibited by the US/UN/EU law and sanctions.

38. Coverage is excluded for treatment and services related to infectious diseases declared to be an outbreak, epidemic, or public emergency by the World Health Organization (WHO), Center for Disease Control and Prevention (CDC), or any other Government or Government Agency or ruling body of the country where the outbreak or epidemic has occurred in. Additionally, such coverage is also excluded if there has been an official warning issued against travel to the area, by the State Department, Embassy, Airline or other Governmental Agency, prior to travel to the affected country. This exclusion will not apply if exposure occurs accidentally or unknowingly while travelling to or from areas not declared to be at risk, or if exposure occurs as a result of residing or working in the area prior to the outbreak.
39. Benefits for enrolling solely for the purpose of obtaining medical treatment, while on a wait list for a specific treatment, or while travelling against the advice of a Physician.
40. Treatment of a hernia, including sports hernia, whether or not caused by a covered Accident.
41. Endoscopic procedures including but not limited to colonoscopy, gastroscopy, and cystoscopy.
42. Extended Care provided at a nursing or rehabilitation facility for skilled and rehabilitation services.

Accidental Death and Dismemberment Exclusions: In addition to the Exclusions and Limitations shown above, the following exclusions also pertain to the Accidental Death and Dismemberment Benefit:

43. Any loss caused directly or indirectly from extortion, kidnap & ransom or wrongful detention of the Insured Person or hijacking of any aircraft, motor vehicle, train or waterborne vessel on which the Insured Person is traveling.
44. Any loss resulting as a fare-paying passenger in a scheduled aircraft or in an employer owned or hired jet or helicopter for transportation of employees.

How to File a Claim

Claim forms are downloadable from www.gbg.com. GBG Administrative Services can also send claims forms by e-mail, upon request. GBG Administrative Services must receive completed forms within **180 days** of treatment to be eligible for reimbursement of Covered Expenses. All paid claims will be available to view on the www.gbg.com website. You must log in and then you will have access to claim status and claim payment or explanation of benefit information. All communication with regard to explanation of benefits will be electronic. Claim payments are subject to Co-Payments, Coinsurance, Deductibles and charges in excess of Usual, Customary and Reasonable.

The claim form is to be used only when a Provider does not bill the Company directly, and when you have out-of-pocket expenses to submit for reimbursement. All claim forms must have itemized bills and receipts attached, and should include the following information: name of patient, printed invoice number, name and entity of medical practitioner or institution, description of services rendered.

Claims submitted by the Provider may be submitted to Insurer directly by the institution or Provider. Bills coming from Providers within the United States should be submitted on HCFA 1500 or UB92 formats.

Mail the Claim Form and documentations to:

GBG Administrative Services
27422 Portola Parkway, Suite 110
Foothill Ranch, CA 92610

Submission of claims by Scan or Online

- Scan claims to: eclaims@gbg.com
- Log-on to www.gbg.com

Status of Claims

Insured Person'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 claims@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. Claim payment information including status and payment will be available electronically for Your review.

Accidental Death and Dismemberment Claims

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

1. An official certificate of death, indicating date of birth of the Insured Person;
2. 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;
3. 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.

Releasing Necessary Information

The Policyholder agrees on behalf of himself and his Dependent(s), to let any Physician, Hospital, Pharmacy or Provider give Insurer all medical information determined by Insurer to be necessary, including a complete medical history and/or diagnosis. Insurer will keep this information confidential. In addition, by applying for coverage, the Policyholder authorizes Insurer to furnish any and all records respecting such Insured including complete diagnosis and medical information to an appropriate medical review board, utilization review board or organization and/or to any administrator or other insurance carrier for purposes of administration of this Policy. There may also be additional health information requests from the Insured Person.

Request for Reproduction of Records

Insurer reserves the right to charge a fee for reproductions of claims records requested by the Insured Person or his representative.

Time Limits

Requests for payment of benefits must be received in Insurer's claims administrator office no later than 180 days following the date on which the Insured Person received the service. Claims received after this date will be excluded from coverage.

Inquiries regarding past claims must be received within 12 months of the date of service to be considered for review.

Subrogation/Indemnity

The Insurer has a right of Subrogation or reimbursement from or on behalf of an Insured Person to whom it has paid any claims if such Insured Person has recovered all or part of such payments from a third party. Furthermore, the Insurer has the right to proceed at its own expense in the name of the Insured Person, against third parties who may be responsible for causing a claim under this Policy or who may be responsible for providing indemnity of benefits for any claim under the Policy.

Claims Appeal

GBG Administrative Services

Attention: Appeals Department
27422 Portola Parkway, Suite 110
Foothill Ranch, CA 92610 USA

Appeals should be submitted within 60 days of receiving your processed claim. Upon appeal, the Insured Person will pay any fees associated with the request of medical records. The GBG Administrative Services appeals committee will review your information and provide a response within 30 business days of receipt. For more detailed information regarding the appeals process, please visit **www.gbg.com**.

If you do not agree with the outcome of a processed claim, you may submit an appeal/grievance online at www.gbg.com (see online forms/applications). Alternatively, you can send a completed Appeal/Grievance Form (available at www.gbg.com) along with all the supporting documents to:

GBG Administrative Services
Attention: Appeals Department
27422 Portola Parkway, Suite 110
Foothill Ranch, CA 92610 USA
www.gbg.com

Appeals Procedure

For the purposes of this section, any reference to "You"', "'Your", or Insured Person also refers to a representative or Provider designated by You to act on Your behalf, unless otherwise noted.

The Company has a two-step appeals/grievance procedure for coverage decisions. To initiate an appeal, You must submit a request for an appeal/grievance in writing within 180 days of receipt of a denial notice. You should state the reason why You feel Your appeal or grievance should be approved and include any information supporting Your appeal/grievance. You may send it to the address above, or go to the website where You can complete an appeal form and submit it to Us.

Level One Appeal

If You are not satisfied with an administrative, Eligibility, rescission of coverage, denial or reduction of benefit or if a health care determination for Pre-Authorization or current care coverage has been denied; You have the right to file an appeal or a grievance within 90 days.

Your appeal/grievance will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity, clinical appropriateness or, being Experimental and/or Investigational will be considered by a health care professional.

For level one appeals, We will respond in writing or electronically with a decision within 15 calendar days after We receive an appeal for a required Pre-Authorization or concurrent care coverage determination (decision). We will respond within 30 calendar days after We receive an appeal for a post service coverage determination. If more time or information is needed to make the determination, We will notify You in writing or electronically to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if (a) the time frames under this process would seriously jeopardize Your life, health, ability to regain maximum function or in the opinion of Your Physician would cause You severe pain which cannot be managed without the requested services; or (b) Your appeal involves non-authorization of an Admission or continuing Inpatient stay. Our medical review agent in consultation with the treating Physician will decide if an expedited review is necessary. When an appeal is expedited, We will respond within 72 hours, followed up in writing or electronically within five days.

Level Two Appeal

If You are dissatisfied with Our level one appeal decision, You may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the appeals committee, which consists of at least three people. Anyone involved in the prior decisions may not vote on the committee. For appeals involving Medical Necessity, clinical appropriateness, or being Experimental and/or Investigational, the committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by Our medical review agent.

For level two appeals We will acknowledge in writing or electronically that We have received Your request and schedule a committee review. For required Pre-Authorization and concurrent care coverage determinations, the committee review will be completed within 15 calendar days. For post-service claims, the committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, We will notify You in writing to request an extension of up to 15

calendar days and to specify any additional time needed by the committee to complete the review. You will be notified in writing of the decision within five working days of the meeting, and within the committee review time frames.

You may request that the Level Two appeal process be expedited if, (a) the time frames under this process would seriously jeopardize Your life, health, ability to regain maximum function or in the opinion of Your Physician would cause You severe pain which cannot be managed without the requested services; or (b) Your appeal involves non-authorization of an Admission or continuing Inpatient stay. Our medical review agent in consultation with the treating Physician will decide if an expedited review is necessary. When an appeal is expedited, We will respond within 72 hours, followed up in writing or electronically within five calendar days.

Independent Review Procedure

If You are not satisfied with the final adverse benefit determination decision of the level two appeal review regarding Your Medical Necessity, clinical appropriateness, or being Experimental and/or Investigational, You may request that Your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Us or Our administrator or any of Our affiliates. A decision to use this external level of appeal will not affect the claimant's rights to any other benefits under the Policy.

There is no charge for You to initiate this independent review process. The Company will abide by the decision of the Independent Review Organization.
In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination or because it is considered to be Experimental and/or Investigational by Our medical review agent. Administrative, eligibility, or benefit coverage reductions or exclusions are not eligible for appeal under this process.

To request a review, You must notify the appeals coordinator within 90 days of Your receipt of the Company's final adverse benefit determination. The Company will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days, when requested and when a delay would be detrimental to Your condition, as determined by Your Physician and the external review agent, the review shall be completed within 72 hours upon receipt of required information.

GBG Assist

GBG Assist must be contacted for the following services:

- Pre-Authorization
- Emergency Services / Medical Evacuation
- Case management

The Company has selected GBG Assist to provide these services. Insured Persons may be required to receive approval from GBG Assist prior to receiving certain treatment. (*See also Pre-Authorization Section.*) Through this process, GBG Assist will:

- Verify eligibility of Insured Person.
- Determine whether the services or supplies are covered.
- Ensure treatment is Medically Necessary and an Emergency.
- Minimize out-of-pocket costs to the Insured Person.

The Company retains the right to refer certain large claims to GBG Assist, which will then be responsible for establishing and monitoring the scope and nature of the care provided. When the Company elects to refer a claim to GBG Assist, in order for treatment to continue to be eligible for reimbursement under the Policy, the Insured Person will be required to follow the procedures indicated by GBG Assist.

GBG Assist will guide you to appropriate facilities and will evaluate the Medical Necessity of the recommended treatment. The intention of this process is not to substitute for the medical judgment of your physician, as the ultimate decision for treatment is up to the Insured Person. Regardless of the decisions taken by the Insured Person, coverage under this Policy is subject to all

stated limitations and exclusions as well as a consideration of the Medical Necessity of the proposed treatment and the effective management of health care costs. Treatment is approved and monitored by GBG Assist, which will be the sole determinant of the nature and scope of treatment.

For Treatment in All Countries contact GBG ASSIST (24 hours)

- Inside USA/Canada Toll Free: +1.866.914.5333
- Worldwide Collect: +1.905.669.4920
- Email: GBGAssist@gbg.com

Definitions

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

Accident – Any sudden and unforeseen event occurring during the policy year period, resulting in bodily injury, the cause or one of the causes of which is external to the victim's own body and occurs beyond the victim'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 transferring (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 means the period from the time that an Insured Person enters a Hospital, Extended Care Facility or other approved health care facility as an inpatient until discharge.

Air Ambulance means an aircraft specially equipped with the necessary medical personnel, supplies and Hospital equipment to treat life-threatening illnesses and/or injuries for persons 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 means the fee or price Insurer determines to be the Usual, Reasonable and Customary Charge for health care services provided to Insured Persons that are covered under the Policy. The Insured Person is responsible for the payment of any balance over the Allowable Charge (except in the U.S. when a Preferred Provider has delivered coverage, then there is no balance due). All services must be medically necessary. Once an allowable charge is established then the deductible, co-payments and any excess charges must be paid by the Insured Person.

Ambulatory Surgical Center means 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.

Birth Center means a facility that: a) is mainly a place for the delivery of a child or children at the end of a normal pregnancy; b) and meets one or both of the following tests: (1) it is licensed as a Birth Center under the laws of the jurisdiction where it is located; and/or (2) it meets all the following requirements: (i) it is operated in accordance with the laws of the jurisdiction where it is located; (ii) it is equipped to perform all necessary routine diagnostic and laboratory tests; (iii) it has trained staff and equipment required to properly treat potential emergencies of the mother and of the child; (iv) it is operated under the full-time supervision of a Physician or a Registered Nurse (R.N.); (v) it has at all times a written agreement with at least one Hospital in the area for immediate acceptance of a patient in the event of a complication; (vi) it maintains medical records for each patient; (vii) and it is expected to discharge or transfer each patient within 48 hours after the delivery.

Class. The Policyholders of all policies of the same type, including but not limited to benefits, deductibles, age group, country, product, plan, year groups, or a combination of any of these.

Chronic Condition – An injury, illness or condition, which does not require hospitalization, which may be expected to be of long duration without any reasonably predictable date of termination, and which may be marked by recurrences requiring continuous or periodic care as necessary.

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

Common Carrier means 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 means 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 means an inpatient stay at an approved extended care facility for necessary skilled treatment or rehabilitation in accordance with the contract.

Congenital Condition means 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.

Co-payment means a specified charge that the Insured Person is required to pay when a medical service is rendered.

Cosmetic Surgery is defined as 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.

Country of Residence is the country is which the Insured Person is living/studying while insured under this Policy.

Covered Expenses means the Reasonable and Customary charges incurred by an Insured Person, while covered under this Policy, for Medically necessary services, treatments or supplies described under the provisions titled Covered Medical Expenses and, if applicable, Covered Dental Expense and/or Covered Vision Expense.

Critical Condition means an immediate life threatening or perilous illness or conditions due to an accident or natural causes, which requires urgent specialized treatment without delay.

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.

Dangerous or Hazardous Activities means any activity that exposes the participant to any foreseeable danger or risk. Examples of dangerous or hazardous activities include, but are not limited to aviation sports, rafting or canoeing involving white water rapids in excess of grade 5, tests of velocity, scuba diving at a depth of more than thirty meters, bungee jumping, and participation in any extreme sport.

Deductible, means the amount of covered Allowable Charges payable by the Insured Person during each policy year before the Policy benefits are applied. Such amount will not be reimbursed under the Policy.

Dependent a member of the Policyholder's family who is enrolled under the policy with the Company after meeting all the eligibility and requirements and for whom premiums have been received by the Company.

Durable Medical Equipment means 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 to be medically necessary. See DME Section for more details and services that are not consider eligible DME benefits.

Eligibility means the requirements that an Insured Person, including the primary Insured Person and/or his dependent's must meet at all times in order to be covered under the this Contract.

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.

Emergency Medical Transportation – In the event of a Life Threatening emergency, when appropriate treatment is not available locally, this policy provides Emergency Medical Transportation to the closest medical facility capable of providing the required care. Should treatment be available locally, but if the Insured Person chooses to be treated elsewhere, transportation expenses shall be the responsibility of the Insured Person.

In the event of such emergency, GBG Assist must be contacted 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 Insured Person shall be transported and the means of transportation. 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 Insured Person. All emergency medical transportation must be arranged, in advance, with GBG Assist at the telephone number located on the back of the Insured Persons I.D. card. Failure to arrange transportation as indicated will result in non-payment of transportation costs.

Examinations means the Company and the Claims Administrator shall have the right and opportunity, through their medical representatives, to examine any person whenever and as often as they may reasonably require within the duration of any claim. The Insured Person shall make available all medical reports and records, as well as requested health information questionnaires, and where required, shall sign all authorization forms necessary to give the Company a full and complete medical history. The Company and the Claims Administrator shall have the right and the opportunity to require an autopsy in the case of death, unless forbidden by law or religious beliefs.

Experimental and/or Investigational means any treatment, procedure, technology, facility, equipment, drug, drug usage, device, or supplies not recognized as accepted medical practice in the United States or by Insurer.

Extended Care Facility means 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 drug 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 means the country where an Insured Person has his true, fixed and permanent home and principal establishment and holds a current and valid passport.

Home Health Care Agency means an agency or organization, or subdivision thereof, that; a) is primarily engaged in providing skilled nursing services and other therapeutic services in the Covered Person'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 means a program: a) for the care and treatment of an Insured Person in his home; b) established and approved in writing by his attending Physician; and c) 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 means 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: a) has obtained any required state or governmental license or Certificate of Need; b) provides service 24-hours-a-day, 7 days a week; c) is under the direct supervision of a Physician; d) has a nurse coordinator who is a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.); e) has a duly licensed social service coordinator; f) has as its primary purpose the provision of Hospice services; g) has a full-time administrator; and h) maintains written records of services provided to the patient.

Hospital means and 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 drug addicts or alcoholics, or similar institutions.

Identification Card (I.D. card) – The card provided to each Policyholder and his Insured Dependents, which outlines the policy benefits, name of the policyholder, Insured Persons, and endorsements, if any. On this card, Insured Persons will find benefit information, as well as contact information for submitting claims and emergency medical treatment.

Illness means a physical sickness, disease, pregnancy and complications of Pregnancy of an Insured Person. This does not include Mental Illness.

Inpatient means a person admitted to an approved Hospital or other health care facility for a medically necessary overnight stay.

Insured Person is an insured student or dependent enrolled for and entitled to coverage under this Policy and for whom the required Premium has been paid.

Life Threatening Emergency means an injury or illness that is acute, with sudden onset of symptoms and poses an immediate risk to a person's life or long term health. The following signs and symptoms include but is not limited to such emergencies; respiratory distress or cessation of breathing, severe chest pains, shock, uncontrolled bleeding, choking, poisoning, prolonged unconsciousness, severe burns, any complaint or observation which indicates head or spinal cord injury.

Lifetime Maximum means the payment specified in the Schedule of Benefits, which is the maximum amount payable by Insurer over the course of Insured Person's lifetime, regardless of changes in coverage of benefit plan.

Maternity Care – The cost of prenatal care, delivery, C-Sections (see Definitions), and postnatal treatment subject to the specific limit. Any complications related to pregnancy including C- section will be treated as maternity and will be subject to the specified limits. Maternity also includes Pre-natal vitamins.

Maximum Benefit means the payment specified in the Schedule of Benefits, for specific services, which is the maximum amount payable by Insurer per person, per policy year (unless otherwise noted) regardless of the actual or allowable charge This is after the Insured Person has met his obligations of deductible, co-payments and any other applicable costs.

Medical Emergency Services mean services provided in connection with an "Emergency", defined as a sudden or unexpected onset of a condition requiring medical or surgical care which the Insured Person secures after the onset of such condition (or as soon thereafter as care can be made available, but in any case not any later than twenty-four (24) hours after the onset) and in the absence of which care an Insured Person would be expected to suffer serious bodily injury or death.

Medical Exclusion means specific provision excluding coverage for conditions or illnesses for the life of this Policy. Exclusions are imposed when the Policy is issued as a condition for the issuance of coverage. Medical Exclusion or Exclusions, if issued as a condition for the issue of coverage, form a part of this Policy through an endorsement or rider or as listed in the Exclusions and Limitations section of the policy.

Medically Necessary means those services or supplies which are provided by Hospital, Physician or other approved medical providers that are required to identify or treat an illness or injury and which, as determined by Insurer, are:

- Consistent with the symptom, or diagnosis and treatment of condition, disease or injury; and
- Appropriate with regard to standards of accepted professional practice; and
- Not solely for the Insured Person's convenience, the Physician's convenience or any other provider's convenience, and
- The most appropriate supply or level of service, which can be provided. When applied to an inpatient, it further means that the medical symptoms or condition require that the services or supplies cannot be safely provided as an outpatient; and
- Is not a part of or associated with the scholastic education or vocational training of the patient; and
- Is not Experimental or Investigative.

Nurse means a person licensed as a Registered Nurse, (R.N.) or Licensed Practical Nurse, (L.P.N.) by the appropriate licensing authority in the areas which he or she practices nursing.

Outpatient means services, supplies or equipment received while not an inpatient in a hospital, or other health care facility, or overnight stay. Outpatient Surgery is inclusive of all invasive procedures including colonoscopy and endoscopy procedures.

Policy Period is the effective date and termination date of coverage under this plan, as shown on the Policy Face Page.

Physician means any person who is duly licensed and meets all of the laws, regulations, and requirements of the jurisdiction in which he practices medicine, osteopathy or podiatry and who is acting within the scope of that license. This term does not include; (1) an intern; or (2) a person in training.

Policy means the agreement between Insurer and the Policyholder. The Policy includes this document, the Policy Declarations, the applicable Schedule of Benefits, any application forms, any medical questionnaires; the last issued identification card, and any amendments or endorsement modification made in accordance with the Policy. This also includes any riders or endorsements purchased by the Policyholder.

Policy Effective Date means the date that this Policy first takes effect, without regard to renewals thereafter.

Policyholder means the entity that holds the Policy and is named as the Policyholder on the Declarations Page of this Policy.

Pre-Authorization – Pre-Authorization is a process by which an Insured Person obtains written approval for certain medical procedures or treatments, from GBG Assist (see the back of your I.D. Card) 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 Insured Person. For full information on how to pre-authorize medical treatment and relevant contact information, refer to pre-authorization section.

Pre-Existing Condition means any illness or injury, physical or mental condition, for which an Insured Person received any diagnosis, medical advice or treatment, or had taken any prescribed drug, or where distinct symptoms were evident prior to the effective date.

Preferred Provider Organization (PPO) – a participating provider, such as Hospital, clinic or Physician that has entered into an agreement to provide health services to persons insured by the Insurer. The Company also maintains an international network of medical providers and facilities with which it has arranged direct billing procedures. Please refer to your Identification card to locate Preferred Providers, or access a list of providers at www.gbg.com.

Premium(s) means the consideration owed by the Policyholder to the Insurer in order to secure benefits.

Premium Payment Date means the recurring date specified in the Policy Declarations upon which the Premium for this Policy is due.

Prescription Drugs – Prescription drugs 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 drugs, or medical supplies even when recommended by a physician, do not qualify as prescription drugs.

Prescription Drug Formulary – A schedule of prescription drugs approved for use which will be covered, if not otherwise excluded by the plan and dispensed through participating pharmacies. It may include tiers in which a different level of copayment applies to each tier.

Professional Sports – Activities in which the participants receive payment for participation.

Provider means the organization or person performing or supplying treatment, services, supplies or drugs.

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. Inpatient rehabilitation is only covered during the acute and sub-acute recovery phase of treatment and only when authorized by the GBG Assist Department.

Repatriation or Local Burial – This is the expense of preparation and the air transportation of the mortal remains of the Insured Person from the place of death to their home country, or the preparation and local burial of the mortal remains of an Insured Person who dies outside his/her home country. This benefit is excluded where death occurs in their home country.

Schedule of Benefits means the summary description of the available benefits, payment levels and maximum benefits, provided under this Policy. The Schedule of Benefits is included with and is part of this Contract.

Sub-Acute Care – Medical care that is somewhat acute, falling between acute and chronic care, but with some acute features.

Subrogation – The term subrogation refers to the substitution of one person in the place of another relative to a lawful claim or right. In a health plan this type of provision allows the plan to be substituted for the covered person in a case where the covered person takes legal action. Theoretically, a subrogation provision permits the health plan to take direct legal action against a responsible third party and, therefore, the health plan could force the covered person to pursue legal remedies, although he may not have intended to do so.

Terrorism – Terrorist activity means an act, or acts, of any person, or group(s) 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 (s) or government (s).

Usual, Customary and Reasonable Charge means the lower of: a) the provider's usual charge for furnishing the treatment, service or supply; or b) the charge determined by the Insurer to be the general rate charged by the others who render or furnish such treatments, services or supplies to persons: (1) who reside in the same country; and (2) whose Injury or Illness is comparable in nature and severity.

The Reasonable and Customary Charge for a treatment, service or supply that is unusual, or not often provided in the area, or that is provided by only a small number of providers in the area, will be determined by the Insurer. The Insurer will consider such factors as: (1) complexity; (2) degree of skill needed; (3) type of specialist required; (4) range of services or supplies provided by a facility; and (5) the prevailing charge in other areas. The term "area" means a city, a county or any greater area, which is necessary to obtain a representative cross section of similar institutions or similar treatment.

Utilization Review Measures – The Company retains the right to determine the medical necessity of a planned treatment. The appropriateness of care and the treatment plan will be reviewed in consultation with the attending physician and alternative care options may be recommended.

Waiting Period - means the period of time beginning with the Insured Person'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.

This policy is insured by:

BULSTRAD LIFE VIENNA INSURANCE GROUP
6, Sveta Sofia Str.
Sofia 1000, Bulgaria