STUDY ABROAD MEDICAL & TRAVEL POLICY

GBG
Insurance Without Borders℠

Study Abroad **Silver Plan**

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Welcome to the Global Benefits Group (GBG) family! 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 GLOBAL BENEFITS GROUP STUDENT MEDICAL AND TRAVEL INSURANCE

Schedule of Benefits

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). Benefits will be paid 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.

MEDICAL BENEFITS	
Maximum Benefit Per Policy Period	$100,000
Deductible Per Policy Period	$50
Country of Residence Coverage	None
Area of Coverage	Worldwide, excluding Country of Residence
Pre-Existing Conditions	Not Covered
Hospitalization and Inpatient Benefits	
Room and Board (semi-private), Intensive Care/Cardiac Care, Hospital Miscellaneous Expenses	100% UCR
Inpatient Consultation by a Physician or a Specialist, Inpatient Surgery, Diagnostic Testing, X-Ray and Laboratory, and Prescription Drugs	100% UCR
Outpatient Benefits	
Physician or Specialist Office Visit, Diagnostic Testing, X-Ray and Laboratory as part of the Office Visit	100% UCR
Emergency Ground Ambulance	100% UCR
Emergency Room	100% UCR
Alcohol Related Medical Treatment	100% UCR, up to a $5,000 Policy Period Maximum
Self-Inflicted Injury	Not Covered
Ambulatory Surgery, Surgeon's Fees, Anesthesia, and Miscellaneous Surgical Center Expenses	100% UCR
Prescription Drugs (Outside the United States)	100%
Emergency Dental Care (Limited to Accidental injury of sound, natural teeth)	100% UCR up to a Maximum of $250 per tooth, $500 Policy Period Maximum
Leisure Sports & Activities	100%

OTHER BENEFITS	
Return of Mortal Remains	100%
Air Ambulance/Medical Evacuation	100%
Bedside Visit	One economy air ticket and hotel accommodation to the place of Hospital Confinement
Search and Rescue Expenses	100% up to a $2,000 Policy Period Maximum
Lost or Stolen Baggage	100% to $1,500 Policy Period Maximum Limited to up to $250 per item, $750 maximum for Valuable Items
Baggage Delay	100% up to $150 per Policy Period
Loss of Passport	Up to $750 per Policy Period
Travel Delay	100% up to $300 per Policy Period
Trip Cancellation and Interruption	Not Covered
Third Party Liability: Personal and Property Damage Includes Legal Expenses	100% up to $250,000 Policy Period Maximum
Money and Documents (tickets, cash and banknotes)	100% up to $1,000 Policy Period Maximum
ACCIDENTAL DEATH & DISMEMBERMENT	
Principal Sum	$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%

General Provisions

The **Policyholder** is the International Benefit Trust.

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

The declarations of the Plan Participant 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 Plan Participant 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 Plan Participant 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 and Conditions of Coverage

This Policy of insurance provides medical and travel related benefits while a Plan Participant is temporarily away from their Country of Residence.

Eligibility

- Students or Faculty travelling outside the U.S. and are engaged in educational activities
- Student minimum age is 16 years and maximum is 72 years.

Application and Effective Date

The Plan Participant'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;

- When the Plan Participant returns to their Country of Residence at the completion of their trip, or
- On the expiration date of the Policy Period. However, if a Plan Participant'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 Plan Participant's evacuation to the Country of Residence.

Pre-Existing Conditions

A Pre-Existing Condition is defined as any Illness or injury, physical or mental, for which a Plan Participant 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.

Pre-Authorization Requirements and Procedures

Pre-Authorization is a process by which a Plan Participant obtains approval for certain non-emergency, medical procedures or treatments prior to the commencement of the proposed medical treatment. This requires that the Plan Participant 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 Plan Participant. To assure full reimbursement for covered services, written approval from GBG Assist must be received by the Plan Participant prior to the commencement of the proposed

medical treatment.

The following services require Pre-Authorization:

- Hospitalization
- Outpatient Surgery
- Air Ambulance
- 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 $10,000 of medical treatment.

The Plan Participant 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.

Medical Emergency Authorizations must be received within 48 hours of the Admission or procedure. In instances of medical emergency, the Plan Participant 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 for Pre-Authorization:

- Pre-Authorization approval does not guarantee payment of a claim in full, as Deductibles, Co-Payments, Coinsurance and 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.

Medical Benefits and Coverage

Areas of Coverage: The Policy is written on a Worldwide basis excluding the Country of Residence.

Policy Period Maximum: Certain payments of benefits are subject to a Maximum Benefit per Policy period, per Plan Participant, as indicated in the Schedule of Benefits.

Hospitalization and Inpatient 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.

Inpatient Ancillary Hospital Services

If Medically Necessary for the diagnosis and treatment of the Illness or injury for which a Plan Participant 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.

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 and treatment of fractures and dislocations. 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 Plan Participant is a patient in a Hospital. 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.

Outpatient Benefits

When a Plan Participant 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 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.

Emergency Ground Ambulance Services

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

Alcohol Related Medical Treatment

Benefits are provided for the medical treatment of Illness or injuries sustained as the result of Alcohol Consumption. Benefits are limited to the amount shown in the Schedule of Benefits.

Self-Inflicted Injury

Insurer will provide benefits for charges related to Medical Treatment required as the result of an intentionally self-inflicted injury or Illness, suicide or attempted suicide, while sane or insane. Refer to your Schedule of Benefits to determine if this benefit is covered.

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, and 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.

Prescription Drugs are limited to the following:

- Approved by the Food and Drug Administration or other regulatory agency;
- Prescribed in writing by a Physician during the Policy Period and dispensed within such time;
- For the direct care and treatment of the Plan Participant's Illness, injury, or condition that is covered under this Policy;
- Must be dispensed outside the United States;
- The Prescription may not exceed a 30-day supply or for longer than the Policy period.

Benefits are payable in accordance with the Schedule of Benefits.

Emergency Dental Care

Emergency Dental Treatment and restoration of sound natural teeth required as a result of an 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 covers leisure sports and activities, including club and intramural sports, meaning such activities that are for relaxation or fun, do not require any special training, and do not heighten the risk of injury or death to an individual.

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

Return of Mortal Remains

The necessary clearances for the return of a Plan Participant's mortal remains by air transport to the Country of Residence 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.

Air Ambulance and Medical Evacuation

Utilization of the medical evacuation provision requires the prior approval of 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 Plan Participant fails to follow these conditions, he 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 Plan Participant shall be transported. GBG Assist contact information can be located on the Plan Participant's Medical Identification Card. The cost of a

person accompanying a Plan Participant is covered under this Policy.

- Emergency evacuation is only covered if related to a Covered Expense 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 Plan Participant 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. GBG Assist contact information can be found on the Medical Identification Card.
- The Plan Participant 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 Plan Participant and an accompanying person will be reimbursed up to the cost of an airplane ticket in economy class only to the Plan Participant's Country of Residence.

Medical Repatriation

If a Plan Participant 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 Country of Residence is necessary. GBG Assist will coordinate return to the Country of Residence. If the Plan Participant refuses Repatriation, coverage will be terminated for failure to meet Eligibility requirements.

Bedside Visit

If the Plan Participant is Hospital confined due to an injury or Illness for more than seven days, or is likely to be confined for more than seven days or is in Critical Condition, the Insurer will pay the cost of one economy round trip air ticket to the place of Hospital Confinement for one person designated by the Plan Participant. This benefit also includes the cost of reasonable hotel accommodation adjacent to the Hospital.

Search and Rescue

Insurer will reimburse the Plan Participant for reasonable search and rescue expenses as a result of an Accident or other life threatening circumstance up to the amount shown in the Schedule of Benefits. The Insurer shall not be liable for any expenses relating to search and rescue operations to find a Plan Participant in the mountains, at sea, in the desert, in the jungle and similar remote locations including air/sea rescue charges for evacuation to shore from a vessel or from the sea.

Lost or Stolen Baggage

Secondary coverage to Common Carrier settlement with reimbursement to the maximum specified in the Schedule of Benefits. No claims will be accepted until after the Plan Participant has filed and received settlement from the Common Carrier. The coverage is in respect of Accidental loss or theft to baggage, clothing, and personal effects owned by the Plan Participant, subject to depreciation tables selected by the Insurer to a maximum payment of:

a. See Maximum Allowed in Schedule of Benefits in respect of any one article, pair or set of articles.
b. See Maximum allowed in the Schedule of Benefits in respect of Valuable Items.

See also Definitions, Exclusions and Limitations.

Conditions:

1. The Plan Participant must observe ordinary proper care in the supervision of the Plan Participant property in all cases of loss;
2. Claims will be evaluated on an "indemnity basis" only and not "new for old". This means the market value of the article less deduction for age, wear, tear and depreciation, or the cost of repair; whichever is the lesser.
3. Claims will not be considered unless proof of ownership and evidence of value is provided;
4. Any amount paid for temporary loss of baggage will be deducted from the final claim settlement if baggage proves to be permanently lost;
5. Proof of a Missing Bag Report must be filed with the Common Carrier;

6. Any amount paid by a Common Carrier in settlement toward the loss will be deducted from the final claim;
7. The Insurer may request any information from the client it deems necessary in the settlement of a claim. Failure to provide such information will result in a denial of the claim;
8. In the event of a claim in respect of a pair or set of articles the Insurer shall only be liable in respect of the value of that part of the pair or set which is lost, stolen or damaged.

Exclusions: The Insurer shall not be liable for:

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

Baggage Delay

Reimbursement per the benefits specified in the Schedule of Benefits in respect of the replacement of necessities in the event of baggage being temporarily lost in transit during the outward journey from the Country of Residence for longer than 12 hours. Benefit does not apply to the return or homeward journey. The following conditions must be met prior to filing a claim:

1. Proof of a Missing Bag Report must be filed with the Common Carrier;
2. Any items purchased after the return of the baggage will not be covered;
3. Any claim must be accompanied by proper receipts with date and time affixed.

Loss of Passport

To pay up to a maximum listed on the Schedule of Benefits, in respect of reasonable expenses necessarily incurred abroad in obtaining the replacement of a Plan Participant's Person loss of stolen passport. Additional expenses for missing flight and extending accommodations are not covered by this benefit.

Travel Delay

Coverage to the Plan Participant if the departure of the coach, aircraft or sea vessel in which he had arranged to travel on the first outward or first return leg of the journey is delayed for at least 24 hours from the time specified in the travel itinerary due to Strike or Industrial Action, bankruptcy, or mechanical breakdown. Compensation shall be documented and provided for all necessary and reasonable expenses for accommodations, food and local transportation minus any compensation paid by the Common Carrier.

An amount up to $100 for the first complete 24 hour period of delay in departure commencing from the original booked departure time as specified in the travel itinerary and up to $100 after each subsequent 24 hour period of delay up to a maximum

specified in the Schedule of Benefits. It is a condition for cover that the Policy is purchased before the delay is known or announced by the Common Carrier.

Conditions: Coverage is not to exceed the specified daily limit and must be accompanied by receipts and documentation validating the Travel Delay.

1. For multiple Plan Participants travelling together claims may be combined to cover the full out of pocket cost but may not be claimed separately and at no time will compensation exceed the specified daily limit;
2. Plan Participants travelling together may not claim additional hotel expenses unless they are staying in separate accommodations and in no case shall exceed the specified daily limits.

Exclusions: The Insurer shall not be liable for claims:

1. If You are departing from Your point of origin and You live within 100 miles of Your address of record, this benefit will not apply for delays at the initial point of departure;
2. Arising from Strike or Industrial Action existing or publicly declared at the time of affecting this Policy.
3. Arising from technical reasons such as aircraft availability due to aircraft/sea vessel being removed from service;
4. Where a Plan Participant has not checked in according to the itinerary supplied and has failed to obtain written confirmation from the Common Carrier (or their handling agents) of the period of or reason for the delay;
5. Arising directly or indirectly from withdrawal from service (temporary or otherwise) of a coach, an aircraft or sea vessel on the recommendation of a Port Authority or the Civil Aviation Authority or of any similar body.

Trip Cancellation and Interruption

All claims are limited to the maximum stated in the Schedule of Benefits regardless of the amount of trips taken during the period of Insurance for each Plan Participant for loss of travel and accommodation for any unused expenses paid or contracted to be paid as a result of the journey/holiday being necessarily and unavoidably cancelled or interrupted due to any cause listed below commencing and occurring during the Period of Insurance provided such expenses are not recoverable from any other source (this benefit is not valid for cruise holiday cancellations). Future travel credits issued by providers for future use are considered compensation and are not reimbursable under this Policy except for reimbursement of fees at the time of rebooking from original cancellation.

Illness, serious injury or death of:

1. The Plan Participant or person with whom he is travelling or had arranged to travel;
2. The spouse, domestic partner, parent, parent-in-law, child, grandchild, brother, sister, or fiancé such person being resident in the Country of Residence, of the Plan Participant, or of the person with whom the Plan Participant is travelling or had arranged to travel;
3. Any person with whom the Plan Participant had arranged to temporarily reside during the period of Insurance. If the Plan Participant elects to continue with their pre-arranged travel, this Policy will pay for accommodation class change from double occupancy to single.

Other Events:

1. Financial Default of an airline, cruise line, or tour operator provided the financial default occurs more than 14 days following a Plan Participants effective date. There is no coverage for the financial default of any person, organization, agency or firm from whom the Plan Participant purchased travel arrangements. This coverage applies only if the Policy was purchased within 15 calendar days of Initial Trip Payment;
2. Strike or Industrial Action resulting in complete cessation of travel services at the point of departure or destination;
3. You or Your traveling companion's principal place of residence or destination being rendered uninhabitable by fire, flood, burglary or other natural disaster within 10 days of departure. The Insurer will only pay benefits for losses occurring within 30 calendar days after a named storm makes the Plan Participant's destination uninhabitable. Uninhabitable is defined as the dwelling is not suitable for human occupancy in accordance with local public safety guidelines;
4. The Plan Participant being subpoenaed, required to serve on a jury, hijacked, or quarantined;
5. The Plan Participant is called to active military service or military leave is revoked or reassigned;
6. Terrorist Incident in a city listed on the Plan Participant's itinerary within 30 days of the Plan Participant's schedule of arrival;

7. The Plan Participant or traveling companion is involuntarily terminated or laid off through no fault of his or her own, provided that he has been an active employee for the same employer for at least two years. Termination must occur following the effective date of coverage. This provision is not applicable to temporary employment, independent contractor or self-employed persons.

Conditions:

1. Injury or Illness of a Plan Participant, traveling companion or family member traveling with the Plan Participant must be so disabling as to reasonably cause a trip to be cancelled or interrupted, or which results in medically imposed restrictions as certified by a Physician at the time of Loss preventing Your continued participation in the trip.
2. If the Plan Participant must cancel or interrupt his trip due to injury or Illness of a family member not traveling with the Plan Participant, it must be because their condition is life-threatening, as certified by a Physician, or they are the sole caretaker.
3. In the event of a failure by the Plan Participant to notify the Travel Agent, Tour Operator or provider of transport/accommodation immediately when it is found necessary to cancel the journey/holiday, the Insurer's liability shall be restricted to the cancellation charges that would have applied at that time.

Exclusions: The Insurer shall not be liable for:

1. Claims where at the time of taking out this Policy and/or prior to booking each separate trip:
   a. A Plan Participant is aware of any medical condition or set of circumstances, which could reasonably be expected to give rise to a claim;
   b. Any person, including those who are not travelling, have an existing condition which may give rise to a claim;
   c. A Plan Participant has, during the 12 months prior to taking out the Policy, suffered from any medical condition which has necessitated consultation or treatment unless declared to and accepted by the Insurer;
   d. A Plan Participant is suffering or has suffered from any previously diagnosed psychiatric disorder, anxiety or depression;
   e. A Plan Participant is receiving, is on a waiting list, or has the knowledge of the need for Inpatient treatment at a Hospital or nursing home;
   f. A Plan Participant is expected to give birth before or within eight weeks of the date of arrival to their Host Country;
   g. A Plan Participant is travelling against the advice of a medical practitioner or for the purpose of obtaining medical treatment abroad;
   h. A Plan Participant has been given a terminal prognosis;
   i. A natural disaster occurs before the effective date of the Plan Participant's Trip Cancellation coverage.
2. Claims involving:
   a. Suicide or attempted suicide, intentional self-injury, the effect of intoxicating liquors or drugs;
   b. Motorcycling, of any kind, as either driver or passenger;
   c. Any circumstance manifesting itself after the date of booking but prior to the date of issue of this Policy;
   d. Disinclination to travel.

Third Party Liability: Personal Damage and Property Damage (including Legal Expenses)

Subject to the limit stated in the Schedule of Benefits**,** this Policy will indemnify each Plan Participant against legal liability for bodily injury to persons other than employees or other members of his family and/or damage to property excluding that owned by or in the custody or control of the Plan Participant during the Period of Insurance inclusive of legal expenses.

Conditions:

1. The insurance limit is for any one Policy, even if multiple losses are incurred by multiple Plan Participants carrying the Policy;
2. The Plan Participant cannot make statements nor admit liability for any loss, damage or Injury caused by them.

Exclusions: The Insurer shall not be liable for**:**

1. Employers' liability, contractual liability or liability to a member of a family or a traveling companion;
2. Animals belonging to or in the care, custody or control of a Plan Participant;
3. Any willful, malicious, or unlawful act;
4. Pursuit of trade, business or profession;
5. Ownership or occupation of land or buildings;
6. Ownership, possession or use of vehicles, aircraft, or motor-powered watercraft;

7. The influence of intoxicating liquor, or the use of firearms;
8. Legal costs resulting from any criminal proceedings.

Legal costs and expenses incurred by a Plan Participant up to a specified maximum in pursuit of compensation and/or damages against a third party arising from the death or personal injury of the Plan Participant during the Period of Insurance.

Conditions:

1. The Insurer shall have complete control over the legal proceedings and the appointment and control of a lawyer;
2. A Plan Participant must follow the legal representative's advice and provide any and all information and assistance as required. Failure to do so will entitle the Insurer to withdraw cover;
3. The Plan Participant must have access to legal documentation to support the claim;
4. Failure by the Plan Participant to comply with all or any of these conditions will entitle the Insurer to render the legal expenses aspect of this Policy void and thereby withdraw cover;
5. The insurance will not extend to covering a Plan Participant in the pursuit of any appeal except at the Insurer's sole discretion;
6. Where there is a possibility of a claim being brought in more than one country the Insurer shall not be liable for the cost if an action is brought in more than one country.

Exclusions: The Insurer shall not be liable for:

1. Costs incurred in pursuit of any claim against a travel agent, tour operator, Common Carrier, accommodation provider, the Insurer or Insurer's agent, or any other commercial entity;
2. Legal expenses incurred prior to the granting of support by the Insurer;
3. Any claims reported more than 90 days after the commencement of the incident giving rise to such claim;
4. Any claim where the law, practices, and/or financial regulations of the country in which the proposed action will take place indicate that the costs of such action are likely to be unreasonably greater than the anticipated value of the compensation award;
5. Costs incurred in pursuance of a claim against any person with whom a Plan Participant had arranged to travel;
6. Any claim where, in the Insurer's opinion, there is insufficient prospect of success in obtaining a reasonable benefit;
7. Any claim where legal costs and expenses are based directly or indirectly on the amount of an award.

Money and Documents (tickets, cash and banknotes)

Reimbursement to each Plan Participant in respect of Accidental loss or theft of cash, banknotes (carried on the Plan Participant), postal or money orders, travel tickets, etc. Proper documentation and police reports required on day of event or discovery of loss.

Exclusions: The Insurer shall not be liable for:

1. Loss or theft not reported to the Police within 24 hours of discovery and a written report obtained;
2. Depreciation in value or shortages due to error or omission;
3. Loss or theft of unattended money except when left in hotel security, safety deposit or safe;
4. Money packed in suitcases or other like receptacles whilst travelling;
5. Money held in trust;
6. Loss or theft of traveler's checks.

Accidental Death and Dismemberment

Accidental Death and Dismemberment Benefits

The Plan Participant 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 Plan Participant incurs a covered loss, we will pay the percentage of the Principal Sum shown in the table. If the covered person sustains more than one such loss as the result of one Accident, the Insurer will only pay one amount, the largest to what the Plan Participant is entitled. The loss must result within 90 days of the Accident.

- 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.

Political and Natural Disaster Evacuation

(Refer to the Policy Face Page to determine if this optional coverage is included)
This includes Emergency evacuation for non-medical reasons, including war, civil unrest, Natural Disasters, or other causes. Payment to offset the cost of obtaining or paying for evacuation during a period of civil unrest, insurrection, or Natural Disasters that could not have been foreseen prior to departure from Your Country of Residence that is posted to or declared by the United States Department of State, UK Foreign Office or validated by the NOAA (National Oceanic Atmospheric Association) in the cases of weather or Natural Disaster. In all cases, the Insurer reserves the right to assess the validity of the claim and its decisions are final.

Coverage is not valid in any country that was on the verge, already in or under duress for a period of 60 days prior to departure from point of origin or Country of Residence.

Choice of Doctors and Preferred Provider Network

The Company maintains an extensive international Preferred Provider Network. You are not required to use this network; however these Providers may invoice the Insurer directly for their services. This eliminates the requirement for the Plan Participant to pay directly for the services and submit the claim for reimbursement to the Insurer. 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.

How to File a Claim

Claims Forms are downloadable from www.gbg.com. International Claims Services can also send claim forms by e-mail, upon request. International Claims Services must receive completed forms within 90 days of treatment to be eligible for reimbursement of covered expenses.

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; and description of services rendered.

Mail the Claim Form and documentation to:

International Claims 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

Accidental Death and Dismemberment
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 Plan Participant;
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.

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 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.

Status of Claims

Plan Participants 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.

Releasing Necessary Information

The Plan Participant agrees 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 Plan Participant authorizes Insurer to furnish any and all records respecting such Plan Participant 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 Plan Participant.

Claims Appeal

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:

International Claims 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 Plan Participant 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 or Your appointed representative has 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 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 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 Experimental and/or Investigational issue, 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. Plan Participants 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 coverage of Plan Participants.
- Determine whether the services or supplies are covered.
- Ensure treatment is Medically Necessary and an emergency.
- Minimize out-of-pocket costs to the Plan Participant.

The Company retains the right to refer certain large claims to GBG Assist, who 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 Plan Participant 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 patient. Regardless of the decisions taken by the patient, 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: GBG ASSIST (24 hours)

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

Terms and Conditions

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 364 days later. 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 Plan Participant. The Insurer must notify the Plan Participant 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 Plan Participant; or
- Termination of a Plan Participant;

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

Duration of Coverage

Benefits are paid to the extent that a Plan Participant receives any of the treatments covered under the Schedule of Benefits following the effective date, including any additional Waiting Periods and up to the date such individual no longer meets the definition of Plan Participant or their last date of coverage as listed in the Policy Face Page.

Compliance with the Policy Terms

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

Change of Risk

The Plan Participant must inform the Company as soon as reasonably possible, of any changes related to the Plan Participant (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 a Plan Participant 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 Plan Participant 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 Plan Participant, it may at any time terminate a Plan Participant or subject his coverage to different terms if the Plan Participant 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 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 Plan Participant. No individual Plan Participant 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 Plan Participant cancels the Policy after it has been issued or reinstated, 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 Plan Participant 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 Plan Participant 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.

Subrogation/Indemnity

The Insurer has a right of Subrogation or reimbursement from or on behalf of a Plan Participant to whom it has paid any claims, if such Plan Participant 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 Plan Participant, 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.

Right to Recovery

If the Insurer makes benefit payments in excess of the benefits payable under the provisions of the Policy, the Insurer has the right to recover such excess from any person with respect to whom such payments were made.

Exclusions and Limitations

All services and benefits described below are excluded from coverage.

1. Services not specifically listed in this plan as Covered Expenses.
2. Expenses incurred in the Country of Residence.
3. Expenses incurred for elective treatment or elective surgery, or expenses that could have been delayed upon return to the Country of Residence. 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 Plan Participant was covered under this Policy. This also includes any surgical treatment for nasal or septal deformity that was not induced by trauma. Any medical complications arising directly or indirectly as a result of a non-authorized elective or cosmetic procedure.
4. Routine physical exams or tests that do not treat an actual Illness.
5. Services, supplies or treatments, including 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.
6. Any services, supplies, treatments including drugs and/or emergency air services (a) not ordered by a Physician, (b) not Medically Necessary and not recommended or approved by a Physician, (c) not rendered under the scope of the Physician's licensing, (d) medical and dental services that do not meet professionally recognized standards or are determined by Insurer to be unnecessary for proper treatment.
7. Telephonic consultations, missed appointments, or "after hours" expenses.
8. 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.
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, sexual enhancement devices, supplements, herbs or drugs, for any reason.

10. 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.
11. Medical expenses resulting from a motor vehicle Accident in excess of that which is payable under any other valid and collectible insurance.
12. 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.
13. Organ transplant and related procedures.
14. 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. Genetic counseling, screening, testing or treatment.
15. Elective abortions; any voluntarily induced termination of pregnancy unless the mother's life is in imminent danger.
16. 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.
17. Treatment of any injury arising directly or indirectly from drug abuse or addiction, except as specified on the Schedule of Benefits. This includes but is not limited to treatment for any injuries caused by, contributed to or resulting from the Plan Participant's use of illegal drugs, or any drugs or medicines that are not taken in the dosage or for the purposed prescribed by the Plan Participant's Physician.
18. Injuries and/or Illnesses resulting or arising from or occurring during the commission or perpetration of a violation of law by a Plan Participant.
19. Eyeglasses; contact lenses; sunglasses.
20. 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.
21. 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.
22. Exceptional Risks: (a) treatment as a consequence of injury sustained while participating in 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.
23. Treatment of Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by and/or related to the HIV Virus.
24. Dental care is excluded from coverage; treatment, services or supplies related to (a) the teeth; (b) the gums other than tumors; (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.

25. 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.
26. 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.
27. 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.
28. Treatment of a hernia, including sports hernia, whether or not caused by a covered Accident.

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:

29. Any loss caused directly or indirectly from extortion, kidnap & ransom or wrongful detention of the Plan Participant or hijacking of any aircraft, motor vehicle, train or waterborne vessel on which the Plan Participant is traveling.
30. 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.

Definitions

Certain words and phrases used in this Policy are defined below. Other words and phrases may be defined where they are used. Throughout this Policy, the terms defined appear with the first letter of each word in capital letters.

Accident means 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.

Acute Care means 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 a Plan Participant 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, Customary and Reasonable charge for health care services provided to Plan Participants that are covered under the Policy. The Plan Participant is responsible for the payment of any balance over the Allowable Charge (except in the U.S. when a Preferred Provider has delivered 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 Plan Participant.

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.

Chronic Condition means 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.

Confinement means an Inpatient stay at an approved Extended Care Facility for necessary skilled treatment or rehabilitation in accordance with the Policy.

Co-Payment means a specified charge that the Plan Participant 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 means the Country where a Plan Participant has his true, fixed and permanent home and principal establishment and holds a current and valid passport.

Covered Expenses means the Usual, Customary and Reasonable charges incurred by a Plan Participant, while covered under this Policy, for Medically Necessary services, treatments or supplies described under the provisions titled Medical Benefits and Coverage.

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 members. 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.

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

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

Eligibility means the requirements that a Plan Participant must meet at all times in order to be covered under this Policy.

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 means that 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 Plan Participant chooses to be treated elsewhere, transportation expenses shall be the responsibility of the Plan Participant.

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 Plan Participant shall be transported and the means of transportation. If the Plan Participant chooses not to be treated at the facility and location arranged by GBG Assist, then transportation expenses shall be the responsibility of the Plan Participant. All Emergency Medical Transportation must be arranged, in advance, with GBG Assist at the telephone number located on the back of the Plan Participant's Medical Identification Card. Failure to arrange transportation as indicated will result in non-payment of transportation costs.

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 the Insurer.

Extended Care Facility means a nursing and/or rehabilitation center approved by the 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 homes, health resorts, homes for the aged, infirmaries or establishments for domiciliary care, Custodial Care, care of drug addicts or alcoholics, or similar institutions.

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.

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

Illness means a physical Illness, disease, pregnancy and complications of pregnancy of a Plan Participant. 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.

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 are 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.

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

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 Plan Participant 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 a Plan Participant would be expected to suffer serious bodily injury or death.

Medical Identification Card (I.D. card) – The card provided to each Plan Participant which outlines the Policy benefits, name of the Plan Participant, and endorsements, if any. On this card, Plan Participants will find benefit information, as well as contact information for submitting claims and emergency medical treatment.

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:

1. Consistent with the symptom, or diagnosis and treatment of condition, disease or injury; and
2. Appropriate with regard to standards of accepted professional practice; and
3. Not solely for the Plan Participant's convenience, the Physician's convenience or any other Provider's convenience; and
4. 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
5. Is not a part of or associated with the scholastic education or vocational training of the patient; and
6. Is not Experimental and/or Investigational.

Missing Bag Report means a formal report of loss as filed with the Common Carrier commonly known as PIR (Passenger Irregularity report) or PAWOB (Passenger arriving without baggage). This must include the 6 digit "CLAIM NUMBER" or the "World Tracer Record Number as provided by the Common Carrier.

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 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.

Period of Insurance or Policy Period means the time benefits are in effect for the Plan Participant; from the start date which is the time the Plan Participant boards a conveyance to their international destination to start their trip to the time they return to

the Country of Residence.

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 an intern or a person in training.

Plan Participant means a Person eligible for coverage as identified in the application form, and for whom proper Premium payment has been made when due, and who is therefore a Plan Participant under the Policy.

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

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

Pre-Authorization is a process by which a Plan Participant obtains written approval for certain medical procedures or treatments, from GBG Assist (see the back of your Medical Identification 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 Plan Participant. 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 a Plan Participant received any diagnosis, medical advice or treatment, or had taken any Prescription Drug, or where distinct symptoms were evident prior to the effective date.

Preferred Provider Network means a Hospital, clinic or Physician that has entered into an agreement to provide specific medical care at negotiated prices. The Company maintains an international network of medical Providers and facilities with which it has arranged direct billing procedures. Please refer to your Medical Identification Card to locate Preferred Providers, or access a list of Providers at www.gbg.com.

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 medical supplies even when recommended by a Physician, do not qualify as Prescription Drugs.

Professional Sports are activities in which the participants receive payment for participation.

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

Rehabilitation means 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 GBG Assist.

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

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 Policy.

Strike or Industrial Action means any form of work stoppage taken by employees, which are carried on with the intention of preventing, restricting, or otherwise interfering with the production of goods or the provision of services.

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 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 who reside in the same country and 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 provides that 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.

Valuable Items means cellular phones, satellite phones, photographic equipment, tablet personal computers, computers, iPods, CD players and personal music and stereo equipment, CD's, computer games and associated equipment, hearing aids, telescopes and binoculars, antiques, jewelry, watches, furs, and articles made of or containing gold, silver or other precious metals or animal skins or hides. Any item of value to be evaluated on a case by case basis.

We, Our, or Us means the Insurer as listed on the Policy face page.

You or Your means the Plan Participant covered under the Policy.

Subscription Agreement

I hereby apply to be a Plan Participant of the International Benefit Trust established in the Cayman Islands (the "trust") and to participate in the insurance coverage extended by GBG Insurance Limited (the "insurers") to Plan Participants under the trust (the "coverage"). I understand that the coverage is not a general health insurance product, but is intended for use in the event of a sudden and unexpected event while traveling outside my Home Country. I understand that the coverage extended to me will terminate upon my return to my Home Country unless I qualify for a benefit period or Home Country coverage. I understand that I may obtain full details of the coverage by requesting a copy of the master policy from the plan manager. I understand that the liability of the insurers as underwriters of the coverage is as provided in the master policy.

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

The Plan Participant undertakes to make all premium payments as they fall due in respect of the coverage extended to them. The trustee shall not be responsible for the administration of such payments.

If the Plan Participant fails to make any premium payment due in respect of the coverage extended to them, subject to the discretion of the insurance company, such coverage will lapse.

The Plan Participant hereby confirms the accuracy of all information validity of all representations and warranties provided to the trustee in connection with its participation in the plan and/or the subscription for the insurance coverage, howsoever provided, including the terms of this subscription agreement,(together "representations & warranties"). The Plan Participant acknowledges that certain of such information will be relied upon by the insurers as providers of the coverage and that any inaccuracy therein may result in the invalidity of such coverage as it relates to the Plan Participant, the loss of coverage and all monies paid in relation thereto. The Plan Participant hereby undertakes to inform the trustee of any change to any of matter that forms the subject of any of the representation & warranties. The Plan Participant hereby undertakes to indemnify and hold harmless the trustee against any loss or damage (including attorney's fees) occasioned by any inaccuracy in any representation & warranty or failure to advise the trustee of any change in any matter that forms the subject of any of the representation & warranties. The Plan Participant agrees that the trustee shall be entitled to rely on and to act in accordance with any written instruction purported to be provided by the Plan Participant and the Plan Participant hereby undertakes to indemnify and hold harmless the trustee against any loss or damage (including attorney's fees} occasioned by the trustee acting in accordance with any such instruction.

Payments under the terms of the coverage shall be paid by the insurers to the Plan Participant or directly to a provider if assignment of benefits has been authorized. The trustee shall not be responsible for the administration of such payments.

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