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)**

<table>
<thead>
<tr>
<th>Worldwide Collect</th>
<th>+1.905.669.4920</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inside USA/Canada Toll Free</td>
<td>+1.866.914.5333</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:GBGAssist@gbg.com">GBGAssist@gbg.com</a></td>
</tr>
<tr>
<td>Website:</td>
<td><a href="http://www.gbg.com">www.gbg.com</a></td>
</tr>
</tbody>
</table>

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 HEALTH INSURANCE
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### Policy Face Page

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured Person Name</td>
<td>PolicyHolder</td>
</tr>
<tr>
<td>Address (Country of Residence)</td>
<td>ResidenceCountry</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>DateOfBirth</td>
</tr>
<tr>
<td>Student Coverage:</td>
<td>PlanFirst</td>
</tr>
<tr>
<td>Plan Number</td>
<td>Personal Liability/Property Coverage:</td>
</tr>
<tr>
<td></td>
<td>PlanSecond</td>
</tr>
<tr>
<td>Member ID #</td>
<td>PolicyID</td>
</tr>
<tr>
<td>Policy Effective Date</td>
<td>StartDate</td>
</tr>
<tr>
<td>Policy End Date</td>
<td>EndDate</td>
</tr>
<tr>
<td>Benefit Amount</td>
<td>Medical Policy Limit:</td>
</tr>
<tr>
<td></td>
<td>OptionalBenefitFirst</td>
</tr>
<tr>
<td></td>
<td>Property and Liability Policy Limit:</td>
</tr>
<tr>
<td></td>
<td>OptionalBenefitSecond</td>
</tr>
<tr>
<td>Law and Jurisdiction</td>
<td>This insurance shall be governed by and</td>
</tr>
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<td></td>
<td>construed in accordance with the laws of</td>
</tr>
<tr>
<td></td>
<td>the Bailiwick of Guernsey and each party</td>
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<td></td>
<td>agrees to submit to the exclusive</td>
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<td></td>
<td>jurisdiction of the Courts of the</td>
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<tr>
<td></td>
<td>Bailiwick of Guernsey.</td>
</tr>
<tr>
<td>Security/Underwriter</td>
<td>Student Coverage:</td>
</tr>
<tr>
<td></td>
<td>GBG Insurance Limited</td>
</tr>
<tr>
<td>Administrative Agent</td>
<td>Personal Liability/Property Coverage:</td>
</tr>
<tr>
<td></td>
<td>XN Financial Services (Canada) Inc.</td>
</tr>
<tr>
<td></td>
<td>Student Coverage:</td>
</tr>
<tr>
<td></td>
<td>Global Benefits Group, Inc.</td>
</tr>
<tr>
<td></td>
<td>27422 Portola Parkway, Suite 110</td>
</tr>
<tr>
<td></td>
<td>Foothill Ranch, California 92610 USA</td>
</tr>
<tr>
<td>Currency</td>
<td>USD</td>
</tr>
<tr>
<td>Annual Premium</td>
<td>AnnualPremium</td>
</tr>
</tbody>
</table>
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 dollar ($) amounts are shown in USD.

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.

<table>
<thead>
<tr>
<th>GENERAL FEATURES AND PLAN SPECIFICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Provider Network</td>
</tr>
<tr>
<td>Annual Maximum</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
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<tr>
<td>Plan Coinsurance</td>
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<tr>
<td></td>
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<tr>
<td>Overall Deductible</td>
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<tr>
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</tr>
<tr>
<td>Office Visit Co-payment, including Student Health Center</td>
</tr>
<tr>
<td>Emergency Room Deductible (waived if admitted)</td>
</tr>
<tr>
<td>Pre-Existing Conditions</td>
</tr>
<tr>
<td>Home Country Coverage</td>
</tr>
<tr>
<td>Area of Coverage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOSPITALIZATION AND INPATIENT BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>• Room and Board (semi-private room)</td>
</tr>
<tr>
<td>• Intensive Care/Cardiac Care</td>
</tr>
<tr>
<td>• Hospital Miscellaneous Expenses</td>
</tr>
<tr>
<td>• Inpatient Consultation (Physician or Specialist)</td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Surgical Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>• Inpatient Surgery or Procedure</td>
</tr>
<tr>
<td>• Assistant Surgeon and Anesthesiologist</td>
</tr>
<tr>
<td>• Reconstructive Surgery</td>
</tr>
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<td></td>
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</tbody>
</table>
### HOPITALIZATION AND INPATIENT BENEFITS (Continued)

**Ambulance Services**
- Emergency Local Ground Ambulance
  - $400 Maximum Benefit per trip
- Emergency Air Ambulance - Pre-authorization Required
  - 100% UCR
  - $2,500 Maximum per Policy Period

**Chemotherapy, Radiotherapy**
- Coverage for chemotherapy and radiotherapy
  - 100% UCR
- Inpatient and Outpatient
  - $15,000 Maximum per Policy Period

**Mental Health**
- Inpatient benefit to treat a covered diagnosis
  - 100% UCR
  - $25,000 Maximum per Policy Period

### OUTPATIENT BENEFITS

**Outpatient or Ambulatory Surgery**
- Outpatient or Ambulatory Surgery
- Outpatient Surgeon Expense
- Anesthesia, Drugs, Medications
  - 100% UCR

**Outpatient Physician Visit**
- General Practitioner or Specialist
- Urgent Care Center
  - 100% UCR up to $80 Maximum Benefit per visit
  - 30 visit Maximum per Policy Period

**Prescription Drugs**
- Up to 31-day supply per prescription
- Includes Contraceptives
  - 100% UCR
  - $10,000 Maximum per Policy Period

**Diabetic Medical Supplies**
- Includes Insulin Pumps and associated supplies
  - Covered Under Prescription Drugs Benefit

**Emergency Room**
- Deductible waived if admitted
  - 100% UCR after Deductible

**Therapeutic Services, Physiotherapy**
- Physical Therapy, Chiropractic, Occupational Therapy, Vocational Speech Therapy, only when prescribed by a Physician
  - 100% UCR up to $50 per visit
  - 12 visit Maximum Benefit per Policy Period per injury or illness

**Homeopathic Care and Acupuncture**
- Treatment for a covered Illness
  - 100% UCR
  - $500 Maximum per Policy Period

**Mental Health**
- Outpatient Treatment
  - 100% UCR
  - 30 Visit Maximum per Policy Period,
  - $3,000 Maximum Benefit per Policy Period
### OUTPATIENT BENEFITS (Continued)

#### Diagnostic Tests and Procedures
- MRI, PET and CT Scans, X-Rays, Pathology, Laboratory, Echocardiography, Ultrasound, Endoscopy (e.g. gastroscopy, colonoscopy, cystoscopy)
- Inpatient and Outpatient
  - 100% UCR
  - $15,000 Maximum per Policy Period

#### HIV, AIDS
- Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), Sexually transmitted diseases and all related conditions
  - Treatment available if condition is not pre-existing
  - 100% UCR

#### Maternity
- Normal delivery including prenatal care, postnatal care and complications of pregnancy.
  - $7,500 Maximum Benefit for normal delivery,
  - $10,000 for C-section delivery

#### Alcohol and Drug Abuse
- Rehabilitative treatment only
- Inpatient or Outpatient
  - 100% UCR
  - $5,000 Maximum per Policy Period

#### Durable Medical Equipment
- Reimbursement of rental up to purchase price
  - 100% UCR
  - $5,000 Maximum Benefit per Policy Period

#### Preventive Care and Annual Exams
- Child Wellness: Includes child immunizations and routine medical exams
  - 0-12 months of age – maximum 5 visits
- Child/Adult Wellness: Annual Exam, Maximum Benefit $100 per Policy Period
  - 100% UCR

#### Extended Care / Inpatient Rehabilitation
- Must be confined to facility immediately following a Hospital stay.
  - 100% UCR
  - 45 Days Maximum per Policy Period

#### Home Health Care
- Private Duty Nursing, Skilled Nursing, Visiting Nurse, Home Health Nursing
  - 100% UCR
  - 120 Days Maximum per Policy Period

#### Emergency Dental Care
- Limited to accidental injury of sound natural teeth sustained while covered under the policy
  - 100% UCR
  - $2,000 Maximum Benefit per Policy Period

#### Palliative Dental Care
- Emergency treatment for relief of dental pain
  - 100% UCR
  - $600 Maximum Benefit per Policy Period

#### Motor Vehicle Accident
- Injuries caused from motor vehicle accidents
  - 100% UCR
  - $15,000 Maximum Benefit per Policy Period
### OUTPATIENT BENEFITS (Continued)

<table>
<thead>
<tr>
<th>Sports and Leisure Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injuries arising from participation in interscholastic, intramural, or club sports</td>
</tr>
<tr>
<td>$15,000 Maximum Benefit per Policy Period</td>
</tr>
</tbody>
</table>

### ADDITIONAL BENEFITS

<table>
<thead>
<tr>
<th>Passport Recovery</th>
<th>$750 per Policy Period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lost Baggage</strong></td>
<td></td>
</tr>
<tr>
<td>• Expense reimbursement due to flight delays</td>
<td>$150 per Item</td>
</tr>
<tr>
<td>$100 Deductible applies</td>
<td>$500 per Policy Period</td>
</tr>
<tr>
<td><strong>ATM Safe</strong></td>
<td>$500 per Occurrence</td>
</tr>
<tr>
<td>Provides lost cash replacement for losses occurring during a robbery at an ATM.</td>
<td></td>
</tr>
<tr>
<td><strong>Medical Evacuation and Repatriation</strong></td>
<td>$250,000 Maximum Benefit per Policy Period</td>
</tr>
<tr>
<td><strong>Return of Mortal Remains</strong></td>
<td>$50,000 Maximum Benefit</td>
</tr>
<tr>
<td><strong>Accidental Death and Dismemberment</strong></td>
<td>$25,000 Maximum Benefit</td>
</tr>
<tr>
<td><strong>Compassionate Care Visit</strong></td>
<td>$1,000 Maximum Benefit per Policy Period</td>
</tr>
</tbody>
</table>

### Accidental Death and Dismemberment

#### Accidental Death and Dismemberment

| Principal Sum for Primary Plan Participant | $25,000 |
| 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 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 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 Plan Participant 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 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 waive any of its provisions.

**Administrative Agent**
Global Benefits Group
27422 Portola Parkway, Suite 110
Foothill Ranch, CA 92610 USA

**Policy Disclaimer**
This GBG Insurance Limited Policy is an international health insurance Policy. As such, this Policy is subject to the laws of Guernsey, Channel Islands, and the Plan Participant should be aware that the laws governing the terms, conditions, benefits and limitations in health insurance policies issued and delivered in other countries including the United States are not applicable to this Policy. If any dispute arises as to the interpretation of this document, the English version shall be deemed to be conclusive and taking precedence over any other language version of this document.

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 to be a Plan Participant**
Participants under the Policy are those persons described as an Eligible Class.

- Student minimum age is 10 years and maximum is 40 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 Plan Participant’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 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 on the earlier of:

- When the Plan Participant returns to their Home Country 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 Home Country.
- Termination of coverage of the Plan Participant 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 Plan Participant withdraws from classes within the first 31 days due to medical necessity that prevents the Plan Participant from attending classes, the Plan Participant 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 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, 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 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.

Pre-Authorization Requirements and Procedures
Certain designated services require Pre-Authorization, and Plan Participants are required to follow the procedures outlined below.

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
- 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 $10,000 of medical treatment per Policy Period

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.
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 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 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 Plan Participant. The Insurer reimburses such Providers up to a Usual, Customary and Reasonable amount as determined by the Insurer. The Provider may bill the Plan Participant the difference between the amounts reimbursed by the Insurer and the Provider’s billed charge. Additionally, the Plan Participant will pay a Coinsurance amount that is higher than if an In-Network Provider were used.

All other Countries: The Plan Participant may utilize any licensed Provider. However, we suggest the Plan Participant 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 Plan Participants 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 charges 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 Plan Participant 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 Plan Participants 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 Plan Participant 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 a Plan Participant’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 Plan Participant. 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 Plan Participant.

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 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;
- 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 Plan Participant’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 Plan Participant is a patient in a Hospital or approved Extended Care Facility. Visits that are part of normal preoperative and postoperative care are covered under the surgical fee and Insurer will not pay separate charges for such care. If Medically Necessary, 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 Plan Participant, which are not Medically Necessary, will not be considered a covered service.

Outpatient Services

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 or Ambulatory Surgery Benefit
We will pay Outpatient or ambulatory 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-Approved 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-1b, 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 Plan Participant 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 a Plan Participant 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 Plan Participant’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.

Homeopathic Care and Acupuncture
Homeopathy and Acupuncture are covered when provided as treatment for a covered Illness and treatment is provided by a certified Acupuncturist or certified Homoeopathist. Services must be pursuant to a 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 Plan Participant’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.
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.

HIV, AIDS and ARC
Benefits are available for Medically Necessary, non-experimental services, supplies and drugs for the treatment of Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), provided the condition(s) are not considered Pre-Existing Conditions.

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 conception is at least 10 months after the effective date for the pregnancy to be covered. The following benefits are only available to the Plan Participant 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 a Plan Participant. Newborn infant’s coverage without notification during the first 14 days will not exceed $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 Plan Participant 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.

Preventive Care
Covered preventive care expenses include routine physical examinations and preventive medical attention, and are payable in accordance with the Schedule of Benefits.

Extended Care Facility Services, Skilled Nursing and Inpatient Rehabilitation
Benefits are available for up to the Daily and Policy Year Maximums as outlined in the Schedule of Benefits for an Inpatient confinement and services provided in an approved extended care facility following, or in lieu of, an admission to a Hospital as a result of a covered illness, disability or injury. Care provided must be at a skilled level and is payable in accordance with the current Schedule of Benefits. Intermediate, custodial, rest and homelike care services will not be considered skilled and are not covered.

Coverage for confinement is subject to Insurer approval. Covered services include the following:
- Skilled nursing and related services on an inpatient basis for patients who require medical or nursing care for a covered illness.
- Rehabilitation for patients who require such care because of a covered illness, disability or injury.
- Insurer has the right to review a confinement, as it deems necessary, to determine if the stay is medically appropriate. A confinement includes all approved extended care facility admissions not separated by at least 180 days.

Home Health Care Including Private Duty Nursing, Skilled Nursing, Visiting Nurse
An initial period of 30 days will be covered if preapproved. An advanced treatment plan signed by the treating Physician is required for the proper treatment of the illness or injury and used in place of in-patient treatment. Home health care includes the services of a skilled licensed professional (nurse or therapist) outside the hospital and does not include custodial care. These service need to meet specified medical and circumstantial criteria to be covered. Thorough case manager review is required.

1. The Insurer considers home nursing care medically necessary when recommended by the Plan Participants primary care and/or treating physician and both of the following circumstances are met:
   - Plan Participant has skilled needs; and
   - Placement of the nurse in the home is done to meet the skilled needs of the Plan Participant only; not for the convenience of the family caregiver.
2. Therapy must:
   - Produce significant improvement in the Plan Participant’s condition in a reasonable and predictable period of time, and
   - Be of such a level of complexity and sophistication, and/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

**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.

**Palliative Dental**
An eligible Palliative Dental condition will mean emergency pain relief treatment to natural teeth or gums and benefits are payable in accordance with the Schedule of Benefits.

**Motor Vehicle Accident**
The Policy covers injuries sustained in a motor vehicle accident in accordance with the benefits shown in the Schedule of Benefits.

**Leisure Sports and Activities**
The Policy covers leisure sports and activities, including interscholastic, intramural, and club 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. Such activities are covered in accordance with the Schedule of Benefits.

**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**

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

**Lost 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 overall in respect of Valuables/Electronic Items.
   c. See Definitions, Conditions and Exclusions.

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

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 Valuables/Electronic Items and money packed in checked baggage or other receptacles while travelling;
7. Loss or damage caused by decay, wear and tear, moth, vermin or atmospheric conditions;
8. Deterioration or mechanical derangement of any kind;
9. Loss due to confiscation or detention by customs or other authority;
10. Damage to sports equipment while in use;
11. Losses of jewelry while swimming;
12. Breakage of or damage to fragile articles and any consequence thereof;
13. Any loss or theft of phones, smart phones, computer equipment including tablet personal computers;
14. Unset precious stones, contact or corneal lenses, spectacles or accessories;
15. Stamps, documents, deeds, manuscripts or securities of any kind;
16. Items of a perishable nature;
17. Business goods, samples, tools of trade or motor accessories;

ATMSafe
This is an exclusive program that provides the Plan Participant with protection against theft when withdrawing cash from an ATM/Bank Machine anywhere in the world. In the event of loss, the Plan Participant will be reimbursed up to the daily withdrawal limit specified in the Schedule of Benefits. All claims require a police report to be filed.

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 Plan Participant 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 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 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 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.
- 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 Home Country.
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 Home Country is necessary. GBG Assist will coordinate return to the Home Country. If the Plan Participant refuses Repatriation, the Policy will be terminated for failure to meet Eligibility requirements.

Return of Mortal Remains
The necessary clearances for the return of a Plan Participant’s mortal remains by air transport to the Home Country will be coordinated by GBG Assist.

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
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, the Insurer will pay the percentage of the Principal Sum shown in the table. If the Plan Participant sustains more than one such loss as the result of one Accident, the Insurer will only pay one amount, the largest to what the Plan Participant is entitled. The loss must result within 90 days of the Accident. Your coverage under the Policy must be in force.

- 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.

Compassionate Care Visit
The Insurer will repatriate the Plan Participant to their Home Country in the event there is a serious life threatening Illness, injury, or death of a spouse, domestic partner, parent, parent-in-law, child, grandchild, brother, sister of fiancé. The Family Member must be a resident in the Home Country of the Plan Participant. In all cases, the decision rest solely with the insurance company’s medical representatives who will make the final and binding determination. In the event of death, a certificate of death must be provided.
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 Plan Participant, 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, other than provided for under the preventive care benefit as listed on the schedule.

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 Plan Participant’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 Plan Participant 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, except as shown on the Schedule of Benefits 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 injury arising directly or indirectly from Alcohol or Drug Abuse or addiction. This includes but is not limited to treatment for any injuries caused by, contributed to or resulting from the Plan Participant’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 Plan Participant’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 a Plan Participant.
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 or training for semi-professional or professional sports, hazardous/extreme sports or intercollegiate 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, if diagnosed as a Pre-Existing Condition.
35. Except for palliative care or 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, micrognathism, or any treatment, services, or supplies to reposition the maxilla (upper jaw), mandible (lower jaw), or both maxilla and mandible. This includes treatment for (TMJOD) 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 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.

**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:

41. 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.

42. 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**

Plan Participant’s wishing to request the status of a claim or have a question about a reimbursement received, please submit the status request form via our website at www.gbg.com or e-mail customer service at 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 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.

Releasing Necessary Information
The Plan Participant 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 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.

Request for Reproduction of Records
Insurer reserves the right to charge a fee for reproductions of claims records requested by the Plan Participant 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 Plan Participant 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 a Plan Participant to whom it has paid any claims if such insured 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.

ATMSafe Claims
This benefit will be payable provided the robbery is reported to the police within 48 hours of its occurrence, and the following documentation is produced upon submission of a claim:
   1. A copy of the police report;
   2. A fully completed dated and signed (by the Plan Participant) claim form;
   3. A copy of the ATM transaction receipt, showing the amount withdrawn, time, date and location of the ATM; and;
   4. Confirmation from the financial institution records that the transaction occurred at the time, date and said location. The Robbery Benefit is limited to two benefits, per policy period.

All claims must be submitted to the Insurer within 10 days from the date of the Robbery.

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 Plan Participant 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 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 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. 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 eligibility of plan participant.
- 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, 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 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 Plan Participant. Regardless of the decisions taken by the Plan Participant, 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).

**Acupuncture** – Treatment of a medical condition, which is covered under the terms of this policy, by needles or laser provided by or ordered by a licensed physician as defined in this policy.

**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 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, Reasonable and Customary 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.

**ATM**: an automatic electronic device designed to permit the Plan Participant to interface with a financial institution without teller assistance using a Registered Card.

**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 Plan Participants 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 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.

**Covered Expenses** means the Reasonable and Customary charges incurred by a Plan Participant, 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 Plan Participant during each policy year before the Policy benefits are applied. Such amount will not be reimbursed under the Policy.

**Dependent** a member of the Plan Participant’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 a Plan Participant, including the primary Plan Participant 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 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 person chooses not to be treated at the facility and location arranged by GBG Assist, then transportation expenses shall be the responsibility of the Plan Participant. All emergency medical transportation must be arranged, in advance, with GBG Assist at the telephone number located on the back of the Plan Participants I.D. card. Failure to arrange transportation as indicated will result in non-payment of transportation costs.

Enrollment Effective Date means the date upon which a Plan Participant’s coverage will become effective under this Policy, as determined by the Policyholder or otherwise.

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 Plan Participant 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 Administrators 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 a Plan participant has his true, fixed and permanent home and principal establishment and holds a current and valid passport.

Homeopathy means a system of alternative medicine that seeks to treat patients by administering small doses of medicines that would bring on symptoms similar to those of the patient in a healthy person. For example, the homeopathic treatment for diarrhea would be a miniscule amount of a laxative.

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 a Plan Participant 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 Plan Participant and his Insured Dependents, which outlines the policy benefits, name of the policyholder, Plan Participants, 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. **Illness** means a physical sickness, 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 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 Plan Participant’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 Plan Participant 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 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 an Plan Participant 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:

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 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.
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.

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

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 a person that has applied for coverage and is named as the Policyholder on the Declarations Page of this Policy.

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

Pre-Authorization – 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 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 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 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 under this Policy.

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 Plan Participant from the place of death to their home country, or the preparation and local burial of the mortal remains of a Plan Participant who dies outside 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: (i) 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.

When PPO providers are available within a 30-mile radius of the Plan Participant’s local residence, the Usual, Reasonable and Customary charge may be the negotiated PPO provider fee for such services.

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 Plan Participant’s Effective Date, during which limited or no benefits are available for particular services. After satisfaction of the Waiting Period, benefits for those services become available in accordance with this plan.
Appendix 1

Personal Property Coverage Agreement
We will provide the insurance described in this policy section in return for the premium and compliance with all applicable provisions of this policy.

We cover the household goods and personal belongings owned or used by you or members of your family, if resident in the same household, while these goods and belongings are anywhere in the world. We also cover the personal belongings of your dependent children while away at school or college during the normal school or college year.

At your request we will cover the personal belongings owned by others while such property is on the part of the residence premises occupied by you. In addition, we will cover at your request, the personal belongings owned by a guest or a residence employee, while this property is in the residence premises occupied by you or while such property is in the physical custody of such employee away from the residence premises.

We will also extend this coverage to your personal belongings while such belongings are in a commercial storage facility or warehouse.

The amount of coverage we provide is the limit of liability shown in the Coverage Summary.

Special Limits of Liability
These limits do not increase the limit of liability shown in the Coverage Summary. The special limit for each following numbered category is the total limit for each occurrence for all property in that numbered category:

1. $100 on money, bank notes, bullion, gold other than goldware, silver other than silverware, platinum, coins and medals;
2. $500 on securities, accounts, deeds, evidence of debt, letters of credit, notes other than bank notes, manuscripts, passports, tickets and stamps;
3. $1,000 on watercraft, including their trailers, furnishing, equipment and outboard motors;
4. $1,000 on trailers not used with watercraft;
5. $1,000 on grave markers;
6. $1,000 for loss by theft of jewelry, watches, furs, precious and semi-precious stones;
7. $1,000 for loss by theft, of silverware, silver-plated ware, goldware, gold-plated ware and pewterware; and
8. $1,500 for loss by theft of electronic equipment's (all items combined)

Property Not Covered
We do not cover:

1. animals, birds or fish;
2. motorized land vehicles except those used to service the residence premises and not licensed for road use;
3. any device or instrument, including any accessories or antennas, for the transmitting, recording, receiving or reproduction of sound which may be operated by power from the electrical system of a motor vehicle, or any tape, wire, record, disc or other medium for use with any such device or instrument while of this property is in or upon a motor vehicle;
4. aircraft and parts;
5. property of roomers, boarders and other tenants, except property of roomers and boarders related to you;
6. property carried or held as samples or for sale or for delivery after sale;
7. business property away from your residence premises and property of any government or subdivision thereof;
8. property contained in an apartment regularly rented or held for rental to others by you; and
9. with respect to replacement cost coverage: antiques, fine arts, paintings, statuary and similar objects which by their inherent nature cannot be replaced with new articles. Also excluded are items whose age and origin contribute substantially to their value including but not limited to memorabilia, souvenirs, and collections, i.e. stamps, coins, etc.;
10. property grown for business purposes.
Additional Coverages

Additional coverages for loss of use
The total limit of liability for all the following coverages under Loss of Use shall be 20% of the amount shown in the Coverage Summary under household goods and personal belongings. This coverage is in excess of the amount shown for household goods and personal belongings in the Coverage Summary.

Additional living expense
If a loss covered under this Section makes the residence premises uninhabitable, we cover any necessary increase in living expense incurred by you so that your household can maintain its normal standard of living. Payment shall be for the shortest time required to repair or replace the premises or, if you permanently relocated, the shortest time required for your household to settle elsewhere. This period of time is not limited by expiration of this policy. Coverage is limited to $1,000.

Prohibited use
If a civil authority prohibits you from use of the residence premises as a result of direct damage to neighboring premises by a Peril Insured Against in this policy, we cover any resulting additional living expense and fair rental value loss for a period not exceeding two weeks during which use is prohibited.

Supplementary Coverages

Debris removal
We will pay the reasonable expense incurred by you in the removal of debris of covered property provided coverage is afforded for the peril causing the loss. Debris removal expense is included in the limit of liability applying to the damaged property. When the amount payable for the actual damage to the property plus the expense for debris removal exceeds the limit of liability for the damage property, an additional 5% of that limit of liability will be available to cover debris removal expense.

Reasonable repairs
We will pay the reasonable cost incurred by you for necessary repair made solely to protect property from further damage provided coverage is afforded for the peril causing the loss. This coverage does not increase the limit of liability applying to the property being repaired.

Trees, shrubs and other plants
We cover trees, shrubs, plants and lawns, on the residence premises, for loss caused by the following Perils Insured Against: Fire or Lightning, Explosion, Riot or Civil Commotion, Aircraft, Vehicles not owned or operated by a resident of the residence premises Vandalism or Malicious Mischief or Theft. The limit of liability for this coverage shall not exceed 10% of the limit of liability that applies to household goods and personal belongings for all trees, shrubs, plants and lawn and not more than $500 for any one tree, shrub or plant. We do not cover property grown for business purposes.

Fire department service charge
We will pay up to $500 for your liability assumed by contract or agreement for fire department charges incurred when the fire department is called to save or protect covered property from a peril insured against. No deductible applies to this coverage.

Property removal
Covered property while being removed from a premises endangered by a peril insured against and not removed for more than 30 days is covered for direct loss from any cause. This coverage does not change the limit of liability applying to the property being removed.

Credit card, forgery and counterfeit money
We will pay up to $500 for:
1. the legal obligation of any Beneficiary to pay because of the theft or unauthorized use of a credit card issued to or registered in any Beneficiary's name;
2. loss to any Beneficiary caused by forgery or alteration of any check or negotiable instrument; and
3. loss to any Beneficiary through acceptance in good faith of counterfeit United States or Canadian paper currency.
Under this coverage we may make any investigation and settle any claim or suit that we decide is appropriate. Our obligation to defend any claim or suit ends when the amount we pay for the loss equals our limit of liability.

If a claim is made or a suit is brought against any Beneficiary for liability under the credit card coverage, we will provide a defense at our expense by counsel of our choice.

We have the option to defend at our expense any Beneficiary or any Beneficiary’s bank against any suit for the enforcement of payment under the forgery coverage.

With respect to the credit card coverage, we do not cover use by a resident of your household, a person who has been entrusted with the credit card, or any person if any Beneficiary has not complied with all terms and conditions under which the credit card is issued. We also do not cover loss arising out of business pursuits or the dishonesty of any Beneficiary.

**Deductible amount**

With respect to loss covered under this Section we shall be liable only when such loss in each occurrence exceeds the amount of the deductible shown in the Coverage Summary and then only for the amount of such excess.

**Perils insured against**

We insure for all risks of direct physical loss or material damage to the property described except:

1. **losses excluded under this section - Exclusions**
   2. freezing of a plumbing, heating or air conditioning system or of a household appliance, or by discharge, leakage or overflow from within the system or appliance caused by freezing, while the residence premises is vacant, unoccupied or being constructed unless you have used reasonable care to:
      a. maintain heat in the building; or
      b. shut off the water supply and drain the system and appliances of water;
   3. **theft**:
      a. This peril includes loss or damage by theft, if someone has broken into or out of the building by using force and violence or has got into the building by deception.
      b. This peril does not include loss caused by theft:
         i. Committed by an “insured”;
         ii. From that part of a “residence premises” rented by an “insured” to someone other than another “insured”; or
         iii. That occurs off the “residence premises” of:
            1) Trailers, semitrailers and campers;
            2) From an unattended vehicle (other than from a locked and concealed boot, concealed luggage compartment or closed glove compartment of a securely locked vehicle which has been broken into by using force and violence); or
            3) Watercraft of all types, and their furnishings, equipment and outboard engines or motors.
      4) Not reported to the police within 24 hours of the theft
   4. **wear and tear; marring; deterioration; inherent vice; latent defect; mechanical breakdown; rust; mold; wet or dry rot; contamination; smog; smoke from agricultural smudging or industrial operations; birds, vermin, rodents, insects or domestic animals. If any of these cause water to escape from a plumbing, heating or air-conditioning system or household appliance, we cover loss caused by the water**;
   5. **breakage of eyeglasses, glassware, statuary, marble, bric-a-brac, porcelain and similar fragile**
   6. **articles, other than jewelry, watches, bronzes, cameras and photographic lenses. There is coverage for breakage of this property by or resulting from fire, lightning, windstorm, hail, smoke other than smoke from agricultural smudging or industrial operations, explosion, riot, civil commotion, aircraft, vehicles, vandalism and malicious mischief, collapse of a building, earthquake, water not otherwise excluded, theft or attempted theft, or sudden and accidental tearing apart, cracking, burning or bulging of a steam or hot water heating system, air conditioning system or an appliance for heating water**;
   7. **dampness of atmosphere or extremes of temperature unless the direct cause of loss is rain, snow, sleet or hail**;
   8. **refinishing, renovating or repairing of property**;
   9. **collision other than collision with a land vehicle, or the sinking, swamping or stranding of watercraft, including its trailer, furnishings, equipment and outboard motors**;
   10. **destruction, confiscation or seizure by order of any government or public authority**.
Exclusions
We do not cover loss resulting directly or indirectly from the following causes:

1. Ordinance or law, meaning enforcement of any ordinance or law regulating the construction, repair, or demolition of a building or other structure;
2. Power interruption, meaning the interruption of power or other utility service if the interruption takes place away from the residence premises. If a peril insured against ensues on the residence premises, we will pay only for loss caused by the ensuing peril;
3. Neglect, meaning neglect of the Beneficiary to use all reasonable means to save and preserve property at and after the time of a loss, or when property is endangered by a peril insured against;
4. War, including undeclared war, civil war, insurrection, rebellion, revolution, warlike act by a military force of military personnel, destruction or seizure or use for a military purpose, and including consequence of any of these. Discharge of a nuclear weapon shall be deemed a warlike act even if accidental;
5. Nuclear hazard, to the extent set forth in the nuclear hazard Clause of this policy; or
6. International transit, meaning while the household goods or personal belongings are aboard any vessel, aircraft or vehicle for the purpose of international transit or during loading or unloading therefrom; or while in storage during such transit; except such property as accompanies the Beneficiary or members of the Beneficiary’s family of the same household as personal baggage. Personal baggage coverage is limited to $1,000;
7. Intentional Loss, Intentional Loss means any loss arising out of any act an “insured” commits or conspires to commit with the intent to cause a loss. In the event of such loss, no “insured” is entitled to coverage, even “insureds” who did not commit or conspire to commit the act causing the loss;
8. Mysterious Disappearance, Mysterious Disappearance means any loss of property due to your inability to locate an item without circumstances to support the theory that the property was stolen.
9. Power Failure, Power Failure means the failure of power or other utility service if the failure takes place off the “residence premises”. But if the failure results in a loss, from a Peril Insured Against on the “residence premises”, we will pay for the loss caused by that peril.

Nuclear hazard
For the purpose of this policy section, nuclear hazard means: any nuclear reaction, radiation, or radioactive contamination, all whether controlled or uncontrolled or however caused, or any consequence of any of these occurrences. Coverage under Personal Property does not apply to loss caused directly or indirectly by nuclear hazard, except that direct loss by fire resulting from nuclear hazard shall be considered loss caused by fire.

General Conditions

Insurable Interest
If more than one person has an insurable interest in the property covered, we shall not be liable to the Beneficiary, for an amount greater than the Beneficiary’s interest, nor shall we be liable for more than the applicable limit of liability.

Your duties after a loss
In case of loss to which this insurance may apply, you shall:

1. For any theft claim, notify the policy within 24 hours of the theft.
2. give immediate notice to us or our agent, and (a) in the case of theft also notify the police and (b) in the case of credit card forgery also notify the credit card issuer;
3. protect the property from further damage, make reasonable and necessary repairs required to protect the property, and keep an accurate record of repair expenditures;
4. prepare an inventory of damage personal property showing in detail, the quantity, description, and amount of loss. (Attach to the inventory all bills, receipts and related documents that substantiate the figures in the inventory);
5. exhibit the damaged property as often as we reasonably require and submit to examination under oath;
6. submit to us, within 60 days after we request, your signed statement of loss which sets forth, to the best of your knowledge and belief;
   a. the time and cause of loss;
   b. interest of the Beneficiary and all others in property involved and all encumbrances on the property;
   c. other insurance which may cover the loss;
   d. changes in title or occupancy of the property during the term of the policy;
e. specifications of any damaged building and detailed estimates for repair of the damage;
f. an inventory of damaged personal property;
g. receipts for additional living expenses incurred and records supporting the fair rental value loss;
h. evidence or affidavit supporting a claim under the credit card, forgery and counterfeit money coverage, stating the amount and cause of loss; and
i. any additional information we request.

Loss settlement
Our responsibility at time of loss to the covered household goods and personal belongings is to repair or replace the lost or damaged property without deduction for depreciation. Our liability shall not exceed the smallest of the following amounts:

1. the total limit of liability for household goods and personal belongings as stated on the Coverage Summary;
2. the replacement cost of the damaged household goods and personal belongings at the time of loss, including if necessary, shipment charges from the country of original purchase and any applicable import taxes and tariffs; or
3. the cost to repair the damage household goods and personal belongings at time of loss.
4. At the Beneficiary’s option, if you do not repair or replace any lost or damaged household goods or personal belongings, they will be valued on an actual cash value basis.

However, if, within 24 months of the date of the loss settlement, you give us notice of your decision to repair or replace any lost or damaged household goods or personal belongings, we will pay you the difference between their replacement cost and the actual cash value originally paid, but we will pay this difference only when household goods or personal belongings that were valued on an actual cash value basis is actually repaired or replaced.

Loss for breakage to glass caused by a peril insured against shall be settled on the basis of replacement with safety glazing materials when required by ordinance or law.

In case of loss to a pair or set we may elect to:

- repair or replace any part to restore the pair or set to its value before the loss; or
- pay the difference between actual cash value of the property before and after the loss.

If we give you written notice within 60 days after we receive your signed, sworn statement of loss, we may repair or replace any part of the property damaged with equivalent property.

We will not recognize any assignment or grant any coverage for the benefit of any person or organization holding, storing or transporting for a fee regardless of any other provision of this policy.

We need not accept any property abandoned by any Beneficiary.

If you and we fail to agree on the amount of loss, either one can demand that the amount of the loss be set by appraisal. If either makes a written demand for appraisal, each shall select a competent, independent appraiser and notify the other of the appraiser’s identity within 30 days of receipt of the written demand.

The two appraisers shall then select a competent, impartial umpire. If the two appraisers are unable to agree upon an umpire within 30 days, you or we can ask a judge of a court of record in the country where the residence premises is located to select an umpire. The appraisers shall then set the amount of the loss. If the appraisers submit a written report of an agreement to us, the amount agreed upon shall be the amount of the loss. If the appraisers fail to agree within a reasonable time, they shall submit their differences to the umpire. Written agreement signed by any two of these three shall set the amount of the loss. Each appraiser shall be paid by the party selecting that appraiser. Other expenses of the appraisal and the compensation of the umpire shall be paid equally by you and us.
Loss payment
We will adjust all losses with you. We will pay you unless some other person is named in the policy to receive payment. Payment for loss will be made within 60 days after we reach agreement with you, entry of a final judgment, or the filing of an appraisal awarded with us.

Other insurance
If a loss covered by this policy is also covered by other insurance, this policy will be the primary coverage.

Suits against us
No action shall be brought unless there has been compliance with the policy provision and the action is started within one year after the occurrence causing loss or damage.

Personal Liability Coverage

Agreement
We will provide insurance described in this policy section in return for the premium and compliance with all applicable provisions of this policy. In any country where the Insurer may be prevented by law or otherwise from carrying out this agreement, the Insurer shall pay any expenses incurred with its written consent in accordance with this agreement.

Liability

Personal Liability
If a claim is made or a suit brought against any Beneficiary for damages because of bodily injury, personal injury, or property damage to which this coverage applies, we will:

1. pay up to the limit of liability shown in the Beneficiary Coverage Summary for the damages for which the Beneficiary is legally liable; and
2. provide a defense at our expense by counsel of our choice. We may make any investigation and settle any claim or suit that we decide is appropriate. Our obligation to defend any claim or suit ends when the amount we pay for damages resulting from the occurrence equals our limit of liability.

Medical payments to others
We will pay the necessary medical expenses incurred or medically ascertained within three years from the date of an accident causing bodily injury. Medical expenses mean reasonable charges for medical, surgical, x-ray, dental, ambulance, hospital, professional nursing, prosthetic devices and funeral services. This coverage does not apply to you or regular residents of your household other than residence employees. As to others, this coverage applies only:

1. to a person on the insured location with the permission of any Beneficiary; or
2. to a person off the insured location, if the bodily injury:
   a. arises out of a condition in the insured location or the ways immediately adjoining;
   b. is caused by the activities of any Beneficiary;
   c. is caused by a residence employee in the course of the residence employee’s employment by any Beneficiary; or
   d. is caused by an animal owned by or in the care of any Beneficiary.

Payments under this coverage are limited to a maximum of $25,000 per person.

Exclusions
Coverage under both the Personal Liability and the Medical Payments to Others does not apply to bodily injury, personal injury or property damage which:

1. is expected or intended by the Beneficiary;
2. arises out of an illness, sickness or disease transmitted intentionally or unintentionally by a covered person to anyone, or any consequence resulting from that illness, sickness or disease.
3. arises out of business pursuits of any Beneficiary or the rental or holding for rental of any part
4. of any premises by any Beneficiary; provided, however that this exclusion (3) shall not apply to (a) activities which are ordinarily incident to non-business pursuits, or (b) the rental or holding for rental of a residence of yours: (i) on an
occasional basis for the exclusive use as a residence, (ii) in part, unless intended for use as a residence by more than two roomers or boarders, or (iii) in part, as an office, school, studio or private garage;
5. arises out of the rendering or failing to render professional services;
6. arises out of any premises owned or rented to any Beneficiary which is not an insured location; arises out of the ownership, maintenance, use, loading or unloading of:
   a. an aircraft;
   b. a motor vehicle owned or operated by, or rented or loaned to any Beneficiary; or
   c. a watercraft:
      i. owned by or rented to any Beneficiary if the watercraft has inboard or inboard-outdrive motor power of more than 50 horsepower or is a sailing vessel, with or without auxiliary power, 26 feet or more in overall length; or
      ii. powered by one or more outboard motors with more than 25 total horsepower, owned by any Beneficiary at the inception of this policy. If you report in writing to us within 60 days after acquisition, an intention to insure any outboard motors acquired prior to the policy period, coverage will apply;
7. is caused directly or indirectly by war, including undeclared war, civil war, insurrection, rebellion, revolution, warlike act by military force or military personnel, destruction or seizure or use for a military purpose, and including any consequence of any of these. Discharge of a nuclear weapon shall be deemed a warlike act even if accidental. Exclusion 6(c) does not apply while the watercraft is stored and Exclusions 5 and 6 do not apply to bodily injury to any residence employee arising out of and in the course of the residence employee’s employment by any Beneficiary.

Coverage under personal liability
Coverage applies to:
Liability assumed under any written contract or agreement, for a residence rented, or lease agreement that is mandated by local law or statute including:

Neighbors and tenants liability
means the property damage you become legally obligated to pay by reason of liability imposed by the articles of the Napoleonic code or similar civil or commercial codes because of:
1. damage for which you are liable as a tenant;
2. damage for which you are liable when the consequences of such damage spread from your premises to the premises of neighbors and co-tenants; or
3. damage for which you are liable, as landlord, as a result of construction defects or lack of maintenance.

Coverage does not apply to:
1. liability assumed under any written contract or agreement by contract or agreement in connection with any business of the Beneficiary;
2. property damage to property owned by the Beneficiary;
3. bodily injury to any person eligible to receive any benefits required to be provided or voluntarily provided by the Beneficiary under any worker’s or workmen’s compensation, non-occupational disability, or occupational disease law; or
4. bodily injury, personal injury or property damage for which any Beneficiary under this policy is also a Beneficiary under a nuclear energy liability policy or would be a Beneficiary but for its termination upon exhaustion of its limit of liability. A nuclear energy liability policy is a policy issued by Nuclear Energy Liability Association, Mutual Atomic Energy Liability Underwriters, Nuclear Insurance Association of Canada, or any of their successors. Also any other nuclear energy liability policy issued by any foreign government or foreign jurisdiction.

Coverage under medical payments to others
Coverage does not apply to:
1. a residence employee if it occurs off the insured location and does not arise out of or in the course of residence employee’s employment by any Beneficiary;
2. any person, eligible to receive any benefits required to be provided or voluntarily provided under any worker’s or workmen’s compensation, non-occupational disability or occupational disease law;
3. any nuclear reaction, radiation or radioactive contamination all whether controlled or uncontrolled or however caused, or any consequence of any of these.
Additional Coverages

We cover claim expenses, first aid expenses and damage to property of others in addition to our limits of liability. With respect to claim expenses, we pay:

1. expenses incurred by us and costs taxed against any Beneficiary in any suit we defend;
2. premiums on bonds required in a suit defended by us, but not for bond amounts greater than the limit of liability for personal liability although are not obligated to apply for or furnish any bond;
3. reasonable expenses incurred by any Beneficiary at our request, including actual loss of earnings (but not loss of other income) up to $100 per day for assisting us in the investigation or defense of any claim or suit; and interest on the entire judgment which accrues after entry of the judgment and before we pay or tender, or deposit in court that part of the judgment which does not exceed the limit of liability that applies.

With respect to first aid expenses, we will pay expenses for first aid to others incurred by any Beneficiary for bodily injury covered under this policy. We will not pay for first aid to you or any other Beneficiary.

With respect to damage to property of others, we will pay up to $500 per occurrence for property damage to property of others caused by any Beneficiary.

We will not pay for property damage:

1. to property insured under Personal Property or any similar type of coverage;
2. caused intentionally by any Beneficiary who is 18 years of age or older;
3. to property owned by or rented to any Beneficiary, a tenant of any Beneficiary, or a resident in your household; or
4. arising out of:
   a. business,
   b. any act or omission in connection with a premises owned, rented or controlled by a Beneficiary, other than the insured location, or
   c. the ownership, maintenance, or use of a motor vehicle, aircraft or watercraft.

General Conditions

Limit of Liability
Regardless of the number of Beneficiaries, claims made or persons injured, our total liability under personal liability stated in this policy for all damages resulting from any one occurrence shall not exceed the limit of liability for such coverage as stated in the Beneficiary Coverage Summary. All bodily injury, personal injury, and property damage resulting from any one accident or from continuous or repeated exposure to substantially the same general conditions shall be considered to be the result of one occurrence.

Medical payments for others
Our total liability under medical payments to others for all medical expense payable for bodily injury to all persons as the result of one accident shall not exceed the limit of liability for Personal Liability as stated in the Coverage Summary.

This insurance applies separately to each Beneficiary. This condition shall not increase our limit of liability for any one occurrence.

Beneficiary’s duties after loss
In case of an accident or occurrence, the Beneficiary shall perform the following duties and cooperate with us in seeing that these duties are performed:

1. give written notice to us or our agent as soon as practicable, which sets forth:
   a. the identity of the policy and Beneficiary;
   b. reasonably available information on the time, place and circumstances of the accident or occurrence; and
   c. names and addresses of any claimants and available witnesses;
2. forward to us every notice, demand, summons or other process relating to the accident or occurrence;
3. at our request, assist in:
   a. making settlement;
b. the enforcement of any right of contribution or indemnity against any person or organization who may be liable to any Beneficiary;
c. the conduct of suits and attend hearings and trials;
d. securing and giving evidence and obtaining the attendance of witnesses;

4. under the coverage - damage to the property of others - submit to us within 60 days after the loss, a sworn statement of loss and exhibit the damaged property, if within the Beneficiary's control;

5. the Beneficiary shall not, except at the Beneficiary's own cost, voluntarily make any payment, assume any obligation or incur any expense other than for first aid to others at the time of the bodily injury.

**Duties of an injured person**

The injured person or someone acting on behalf of the injured person seeking medical payments coverage shall:

1. give us written proof of claim, under oath if required, as soon as practicable;
2. execute authorization to allow us to obtain copies of medical reports and records; and
3. the injured person shall submit to physical examination by a physician selected by us when and as often as we reasonably require.

**Payment of claim**

Payment under the medical payments to others is not an admission of liability by a Beneficiary or by us.

**Suits against us**

No action shall be brought against us unless there has been compliance with the policy provisions.

No one shall have any right to join us as a part to any action against any Beneficiary. Further, no action with respect to personal liability shall be brought against us until the obligation of the Beneficiary has been determined by final judgment or agreement signed by us.

**Bankruptcy of any Beneficiary**

Bankruptcy or insolvency of any Beneficiary shall not relieve us of any of our obligations under this policy.

**Other insurance**

Our personal liability insurance is excess over any other valid and collectible insurance except insurance written specifically to cover as excess over the limits of liability that apply in this policy.

**Political Risk Coverage**

**Agreement**

The Insurer will indemnify the Beneficiary against loss sustained during the policy period subject to the limit of liability stated in the Coverage Summary, as a direct result of:

1. War; or
2. Civil War and Insurrection; or
3. Expropriatory Action; or
4. Acts of sabotage or Terrorism.

All are subject to a waiting period of 60 days from the date of loss before payment will be paid. All losses are subject to a deductible, per occurrence of $200. The limit of total liability for this coverage is equal to the sum of the limits, for household goods and personal belongings, and Valuable articles.

**Definitions**

Acts of sabotage or Terrorism: means politically motivated destruction of or damage to a Beneficiary's personal property of state-sponsored and government-directed terrorism, or by an organized political group which advocates the overthrow of the established political authorities in the country of domicile.

**Civil War and Insurrection:** means any mass-based, sustained, non-intermittent and cohesively organized series of actions of insurrection, rebellion, revolution, or civil war which occur within the project country, or acts of terrorism (including but not
limited to state-sponsored terrorism) which occur directly and explicitly in the project country as part of such insurrection, rebellion, revolution, or civil war. It is agreed that acts of sabotage or terrorism do not in themselves automatically qualify as acts of civil war and insurrection unless such activity occurs within the broader context of mass-based, sustained, non-interruption and cohesively organized insurrection, rebellion, revolution or civil war.

Date of Loss: means the date during the policy period from which the waiting period begins and on which the occurrence resulting in a loss first happens.

Expropriatory Action: means any action commencing during the policy period of confiscation, expropriation, forced abandonment, nationalization, deprivation, or requisition which is taken, authorized, or ratified by the government of the country, which continues consecutively throughout the waiting period and directly, effectively, arbitrarily and significantly denies or precludes the Beneficiary from exercising control over the use or disposition of a substantial portion of his property.

Waiting Period: means the consecutive period of time, beginning with the date of loss or the date of expropriation, which is required to expire before any action taken or sustained will be deemed to have become a loss.

War: means hostile or warlike action, including action in hindering, combating, or defending against an actual, impending, or expected act by (1) any government or sovereign power or any authority maintaining or using military, naval, or air forces; (2) any military, naval, or air forces, or (3) any agent of any such government, power authority, or forces.

General Conditions

Agreement
These General Conditions apply to all policy coverages.

1. Policy Period and Territory. The policy period is shown on the Coverage Summary. These policy sections apply only to loss which occurs during the policy period. Where legally permissible for us to make payment, the policy covers the Beneficiary worldwide.

2. Concealment or Fraud. We do not provide coverage for any Beneficiary who has intentionally concealed or misrepresented any material fact or circumstance relating to this insurance.

3. Liberalization Clause. If we adopt any revision which would broaden the coverage under any policy section without additional premium within 60 days prior to or during the policy period, the broadened coverage will immediately apply to the affected policy section.

4. Waiver or Change of Policy Provisions. A waiver or change of any provision of this policy must be in writing by us to be valid. Our request for an appraisal or examination shall not waive any of our rights.

5. Cancellation.
   a. The Beneficiary or the Named Insured may cancel this policy at any time by returning it to us or by notifying us in writing of the date cancellation is to take effect. We will refund a pro rata return premium for any unearned premium paid after one full year of coverage. If cancellation is requested, any return premium, for coverage less than one year, will be based on our short rate table.
   b. We may cancel this policy by notifying in writing the Beneficiary or the Named Insured, at our election, of the date cancellation takes effect. If we elect to notify the Named Insured, the Named Insured must notify the Beneficiary. This cancellation notice may be delivered or mailed to the mailing address shown on the Coverage Summary. Proof of mailing shall be sufficient proof of notice.
      i. When the Beneficiary or the Named Insured has not paid the premium, whether payable to us or to our agent or under any finance or credit plan, we may cancel at any time by giving notice at least 10 days before the date cancellation takes effect.
      ii. If there has been a material misrepresentation of fact which if known to us would have caused us not to issue the policy, we may cancel by giving notice at least 30 days before the date cancellation takes effect.
   c. When this policy is cancelled, the premium for the period from the date of cancellation to the expiration date will be refunded. When we cancel, the return premium will be pro rata.
   d. If the return premium is not refunded with the notice of cancellation or when this policy is returned to us, we will refund it within a reasonable time after the date cancellation takes effect.
6. Non-Renewal. We may elect not to renew this policy. We may do so by delivering, or mailing to the mailing address shown in the Coverage Summary, written notice at least 30 days before the expiration date of this policy. Proof of mailing shall be sufficient proof of notice.

7. Termination. A Beneficiary’s coverage under this policy will terminate automatically without the requirement of notice in the event of (1) loss of expatriate status; or (2) retiring from or stopping work; or (3) a change in the Beneficiary’s employer. In all cases of termination of the policy during an insurance period, the portion of the premium relating to the period after termination of the policy shall be repaid by us to the Beneficiary or Named Insured if it was collected in advance.

8. Assignment. Assignment of this policy shall not be valid unless we have given our written consent.

9. Subrogation. Any Beneficiary may waive in writing before a loss all rights of recovery against any person. If not waived, we may require an assignment of rights of recovery for a loss to the extent that payment is made by us.

If an assignment is sought, any Beneficiary shall sign and deliver all related papers and cooperate with us in any reasonable manner.

Subrogation does not apply to Medical Payments to Others or Damage to Property of Others.

10. Death. If the Beneficiary shown in the Coverage Summary or their spouse, if a resident of the same household, dies:

   a. we insure the legal representative of the deceased but only with respect to the premises and property of the deceased covered under the policy at the time of death;
   b. Beneficiary includes:
      i. any member of your household who is a Beneficiary at the time of your death, but only while a resident of the resident premises; and
      ii. with respect to your property, the person having proper temporary custody of the property until appointment and qualification of a legal representative.

Agreement
Throughout these policy sections “you” or “your” refer to the “Beneficiary” shown in the Coverage Summary and the spouse if a resident of the same household, and “we”, “us”, refer to the Insurer providing this insurance. In addition, certain words and phrases used in this policy are defined as follows:

1. Beneficiary means you, a spouse who lives with you, and the following residents of your household:
   a. your relatives;
   b. any other person under the age of 25 who is in the care of any person named above.

Under Personal Liability Coverage, Beneficiary also means:

c. with respect to animals or watercraft to which this property applies, any person or organization legally responsible for these animals or watercraft which are owned by you or any person included in 1a or 1b. A person or organization using or having custody of these animals or watercraft in the course of any business, or without permission of the owner is not a Beneficiary;

d. with respect to any vehicle to which this policy applies, any person while engaged in your employment or the employment of any person included in 1a or 1b.

2. Bodily injury means bodily harm, sickness or disease, including required care, loss of services and death resulting therefrom.

3. Business includes trade, profession or occupation.

4. Insured Location means:
   a. the residence premises;
   b. the part of any premises, other structures, and grounds, used by you as a residence and which is shown in the
   c. Declarations or which is acquired by you during the policy period for your use as a residence;
   d. any premises used by you in connection with the premises included in 4a or 4b;
   e. any part of a premises not owned by any Beneficiary but where any Beneficiary is temporarily residing;
   f. vacant land owned by or rented to any Beneficiary other than farm land;
   g. land owned by or rented to any Beneficiary on which a one or two family dwelling is being constructed as a residence for any Beneficiary;
   h. individual or family cemetery plots or burial vaults of any Beneficiary;
i. any part of a premises occasionally rented to any Beneficiary for other than business purposes.

5. Motor Vehicle means;
   a. a motorized land vehicle designed for travel on public roads or subject to motor vehicle registration. A motorized land vehicle in dead storage on an insured location is not a motor vehicle.
   b. a trailer or semi-trailer designed for travel on public roads and subject to motor vehicle registration. A boat, camp, home or utility trailer not being towed by or carried on a vehicle included in 5a is not motor vehicle;
   c. a motorized golf cart, snowmobile, or other motorized land vehicle owned by any Beneficiary and designed for recreational use off public roads, while off an insured location. A motorized golf cart while used for golfing purposes is not a motor vehicle;
   d. any vehicle while being towed by or carried on a vehicle included in 5a, 5b, or 5c.

6. Named Insured means the employer shown in the Named Insured Coverage Summary.

7. Personal Injury includes, but is not limited to:
   a. disability, shock, mental anguish and mental injury;
   b. false arrest, false imprisonment, wrongful entry or eviction wrongful detention, malicious prosecution or humiliation; and
   c. libel, slander, defamation of character or invasion of rights of privacy; including death resulting therefrom;
   d. sustained by any person.

8. Property Damage means physical injury to or destruction of tangible property, including loss of use of this property.

9. Residence Employee means an employee of any Beneficiary who performs duties in connection with the maintenance or use of the residence premises, including household or domestic services, or who performs duties elsewhere of a similar nature not in connection with the business of any Beneficiary.

10. Residence Premises means the one or two family dwelling, other structures, and grounds or that part of any other building where you reside and which is shown as the residence premises in the Coverage Summary.
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 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 purport 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.
Global Benefits Group offers worldwide expertise, Products and services unbound by geographic constrains.

Any Country.
Any Nationality.