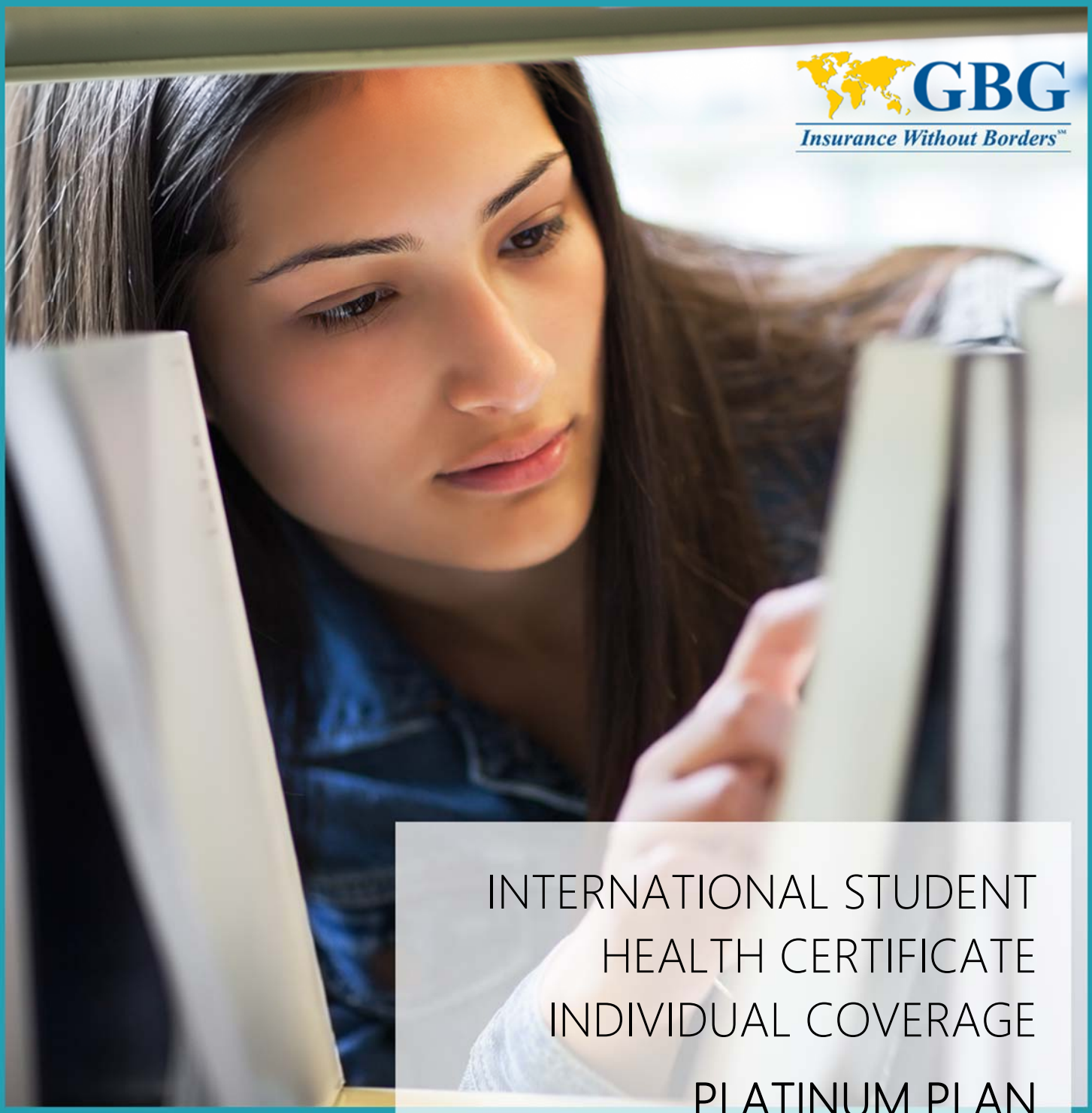

GBG
Insurance Without Borders℠

INTERNATIONAL STUDENT HEALTH CERTIFICATE INDIVIDUAL COVERAGE

PLATINUM PLAN

GLOBAL STUDENT PLANS
GSP
Designed for Better Health

Platinum Plan

Policy #s: 444810; 444812; 444820

Platinum Plan

Welcome. 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.

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. is most cost efficient***. 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 must be obtained from any CVS/Caremark pharmacy***. Present your Medical Identification card to the pharmacist along with the Copayment, at the time of purchase. The pharmacy will bill GBG directly for your prescription. See the section titled, "How to File a Claim" for instructions on reimbursement. A list of participating pharmacies can be viewed at www.gbg.com.
- ***Hospital Emergency Rooms*** should only be used in medical emergency situations. A medical emergency situation is where your life or health is in jeopardy. Using an emergency room is very expensive. You should not use an emergency room for convenience or for any reason other than a serious medical emergency.

How You Can Reach Us

Questions about Enrollment, ID Card, Waiver Assistance: 310-904-8810 or info@1gsp.com or WeChat: GSP-INSURE

- **To enroll in this plan, please visit: www.1gsp.com**

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

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

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

Platinum Plan

SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary outline of the benefits covered under this insurance plan. All benefits described are subject to the definitions, exclusions and provisions. The following benefits are subject to the Plan Participant's Deductible, Copayment, and Coinsurance amount. After satisfaction of the Deductible, the Insurer will pay eligible benefits set forth in this Schedule at the specified Plan Coinsurance and Reimbursement Level.

GENERAL FEATURES AND PLAN SPECIFICATIONS			
U.S. Provider Network	Aetna		
Area of Coverage	Worldwide, excluding Home Country		
Maximum Benefit Payable per Period of Insurance	Unlimited		
Lifetime Maximum	Unlimited		
Individual Deductible per Plan Participant per Period of Insurance[1]	Three available options:		
• In-Network Provider	$100	$500	$1,500
• Out-of-Network Provider	$250	$750	$2,500
Plan Coinsurance • In-Network Provider • Out-of-Network Provider (unless otherwise stated)	80% Preferred Allowance 70% UCR		
Outpatient Office Visit Copayment • In-Network and Out-of-Network Providers • Not including Student Health Center	$25		
Emergency Room Copayment • In-Network and Out-of-Network Providers • Waived if admitted	$100 per Occurrence		
Urgent Care Center • In-Network and Out-of-Network Providers	$50 Copayment per Occurrence		
Out-of-Pocket-Maximum [2] • Family is 2x Individual	$6,350 (including Deductible) Unlimited if an Out-of-Network Provider in the U.S. is used		
Pre-Existing Conditions	Pre-Existing Conditions are covered without a Waiting Period		

Note: All Deductibles and Copayments will be waived when treatment is rendered at the Student Health Center. Benefits will be paid at the In-Network Coinsurance percentage, subject to Usual, Customary and Reasonable charges.

[1] The deductible for expenses incurred for In-Network Providers in the U.S. and expenses incurred Outside the U.S. are combined. The deductible for expenses incurred for Out-of-Network Providers is separate.

[2] The Out-of-Pocket Maximum is inclusive of the Deductible and Copayments including the Prescription Drug Copayment.

COVERED SERVICES AND BENEFIT LEVELS Subject to Deductible, Coinsurance, and Maximum Benefit per Period of Insurance.	WHAT THE INSURANCE PLAN COVERS The following Coinsurance applies for In-Network Providers in the U. S. or for expenses incurred outside the U. S. Coinsurance reduces to 70% UCR when Out-of-Network Providers in the U.S. are used.
HOSPITALIZATION AND INPATIENT BENEFITS	
Accommodations including semi-private room	80% Preferred Allowance
Intensive Care/Cardiac Care	80% Preferred Allowance
Inpatient Consultation by a Physician or Specialist	80% Preferred Allowance
Hospital Miscellaneous Expenses	80% Preferred Allowance
Pre-Admission Testing • Payable within 3 working days prior to Admission	80% Preferred Allowance
Extended Care/Inpatient Rehabilitation • Maximum Benefit per Period of Insurance: 45 days • Must be confined to facility immediately following a hospital stay	80% Preferred Allowance
Registered Nurse's Services • Private Duty Nursing Care	80% Preferred Allowance
OUTPATIENT BENEFITS	
Physician Visit/Consultation by Specialist • Primary Care Physician or Specialist • $25 Copayment per visit (In-Network and Out-of-Network)	80% Preferred Allowance
Diagnostic Testing • X-Ray and Laboratory • MRI, PET, and CT Scans • Inpatient and Outpatient	80% Preferred Allowance
Therapeutic Services, Physical Therapy, Manipulative, Cardiac Rehab, Vocational and Speech Therapy, and Acupuncture • Maximum Benefit per Period of Insurance: 12 visits per Injury/Illness	80% Preferred Allowance

COVERED SERVICES AND BENEFIT LEVELS Subject to Deductible, Coinsurance, and Maximum Benefit per Period of Insurance.	WHAT THE INSURANCE PLAN COVERS The following Coinsurance applies for In-Network Providers in the U. S. or for expenses incurred outside the U. S. Coinsurance reduces to 70% UCR when Out-of-Network Providers in the U.S. are used.
SURGICAL BENEFITS (INPATIENT/OUTPATIENT)	
Inpatient, Outpatient or Ambulatory Surgery **Includes:** • Surgeon's Fees • Anesthesiologist • Facility fees • Laboratory tests • Medications and dressings • Other medical services and supplies Note: when 2 or more procedures are performed through the same incision, the Maximum Benefit will not exceed 50% of the 2nd procedure, and 50% of all subsequent procedures.	80% Preferred Allowance
EMERGENCIES	
Emergency Room and Medical Services • $100 Copayment waived, if admitted (In-Network and Out-of-Network)	80% Preferred Allowance
Ambulance Services • Emergency Local Ground Ambulance • Out-of-Network reimbursed at 80%	80% Preferred Allowance
Emergency Dental • Limited to accidental Injury of sound natural teeth sustained while covered • Maximum Benefit per Period of Insurance: $1,000	70% Preferred Allowance up to $250 per tooth
MATERNITY CARE	
Normal delivery or Medically Necessary C-Section, prenatal, postnatal care and complications of pregnancy	80% Preferred Allowance
OTHER BENEFITS (INPATIENT/OUTPATIENT)	
Allergy Testing and Treatment • Allergy serum and injection • $25 Copayment per visit (In-Network and Out-of-Network)	80% Preferred Allowance
Home Health Care Including Nursing Services	80% Preferred Allowance
Mental Health • To treat a covered diagnosis • $25 Copayment per Outpatient visit (In-Network and Out-of-Network)	80% Preferred Allowance

COVERED SERVICES AND BENEFIT LEVELS Subject to Deductible, Coinsurance, and Maximum Benefit per Period of Insurance.	WHAT THE INSURANCE PLAN COVERS The following Coinsurance applies for In-Network Providers in the U. S. or for expenses incurred outside the U. S. Coinsurance reduces to 70% UCR when Out-of-Network Providers in the U.S. are used.
OTHER BENEFITS (INPATIENT/OUTPATIENT) (CONTINUED)	
Transplant Services (Human Organ, Bone Marrow, Stem Cell) • Expenses for Donor are not covered. • Institute of Excellence required in the U.S • No benefits when an Out-of-Network Provider is used	80% Preferred Allowance
Pediatric Dental Services	50% Preferred Allowance
Pediatric Vision Services	See Pediatric Vision Schedule
Urgent Care • $50 Copayment per visit (In-Network and Out-of-Network) • All services rendered during the visit will be paid as specified in the Schedule of Benefits	80% Preferred Allowance
Voluntary HIV Screening • During Emergency Room visit	100% Preferred Allowance
Elective Abortion • Maximum Benefit per Period of Insurance: $1,500	80% Preferred Allowance
Preventive Care and Annual Exams • 0-12 months: Exam, immunizations • Child/Adult: Annual Exam, immunizations • Deductible does not apply • No benefits if an Out-of-Network provider is used	100% Preferred Allowance
Habilitative Services for the Treatment of Congenital or Genetic Birth Defects	80% Preferred Allowance
Chemotherapy, Radiotherapy	80% Preferred Allowance
Diabetic Medical Supplies • Includes Insulin Pumps and associated supplies • Outpatient self-management training, education, and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered health care professionals.	80% Preferred Allowance
Durable Medical Equipment • Reimbursement of rental up to purchase price	80% Preferred Allowance
Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV +) , AIDS Related Complex (ARC), Sexually transmitted diseases and all related conditions	80% Preferred Allowance

COVERED SERVICES AND BENEFIT LEVELS Subject to Deductible, Coinsurance, and Maximum Benefit per Period of Insurance.	WHAT THE INSURANCE PLAN COVERS The following Coinsurance applies for In-Network Providers in the U. S. or for expenses incurred outside the U. S. Coinsurance reduces to 70% UCR when Out-of-Network Providers in the U.S. are used.
OTHER BENEFITS (INPATIENT/OUTPATIENT) (CONTINUED)	
Alcohol and Substance Abuse • Institutions specializing in or primarily treating substance use disorders are not covered	80% Preferred Allowance
Motor Vehicle Accident • $25 Copayment per visit (In-Network and Out-of-Network)	80% Preferred Allowance
Prescription Drugs • Mail order through CVS/Caremark at 2.5 times the retail Copayment up to a 90-day supply • Includes contraceptives • CVS/Caremark network pharmacy is required. • No benefits when a non-CVS pharmacy is used.	$20 Copayment per prescription for Tier 1 $40 Copayment per prescription for Tier 2 $60 Copayment per prescription for Tier 3 (up to a 31-day supply per prescription)
Hospice Care	80% Preferred Allowance
Medical Evacuation/Repatriation	100% Preferred Allowance
Repatriation of Remains	$50,000 Maximum Benefit
War and Terrorism	Included

ACCIDENTAL DEATH AND DISMEMBERMENT

ACCIDENTAL DEATH AND DISMEMBERMENT	
Principal Sum for Primary Plan Participant	$15,000
Time Period for Loss	90 days
Loss of:	**Benefit:**
Accidental Death	$15,000
Two or More Members [3]	$15,000
One Member	$12,500

[3] **Member** means hand, arm, foot, leg, or eye.

SCHEDULE FOR PEDIATRIC VISION SERVICES

Vision Care Service	Frequency of Service	In-Network Benefit	Out-of-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam	Once per year	100% after a Copayment of $20	50% of the billed charge
Eyeglass Lenses	Once per year		
• Single Vision		100% after a Copayment of $40	50% of the billed charge
• Bifocal		100% after a Copayment of $40	50% of the billed charge
• Trifocal		100% after a Copayment of $40	50% of the billed charge
• Lenticular		100% after a Copayment of $40	50% of the billed charge
Lens Extras	Once per year		
• Polycarbonate Lenses		100%	100% of the billed charge
• Standard scratch-resistant coating		100%	100% of the billed charge
Eyeglass Frames	Once per year		
• Eyeglass frames with a retail cost up to $130		100%	50% of the billed charge
• Eyeglass frames with a retail cost of $130-$160		100% after a Copayment of $15	50% of the billed charge
• Eyeglass frames with a retail cost of $160-$200		100% after a Copayment of $30	50% of the billed charge
• Eyeglass frames with a retail cost of $200-$250		100% after a Copayment of $50	50% of the billed charge
• Eyeglass frames with a retail cost greater than $250		60%	50% of the billed charge
Contact Lenses fitting and evaluation	Limited to a 12-month supply		
• Covered Contact Lens Selection		100% after a Copayment of $40	50% of the billed charge
• Necessary Contact Lenses		100% after a Copayment of $40	50% of the billed charge

1.0 GENERAL PROVISIONS

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

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

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

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

In the event of any conflict between the Master Policy and the Schedule of Benefits, the Schedule of Benefits will govern.

2.0 ELIGIBILITY

2.1 Eligible Classes

International students or other persons with a current passport who; 1) are engaged in educational activities, 2) are temporarily located outside the Home Country as a non-resident alien, 3) have not obtained permanent residency status in the U.S. 4) is enrolled in an associate, bachelor, master, or Ph.D. degree program, at a university or other educational institution with no less than 6 credit hours (unless such school's full-time status requires less credited hours and the student is graduating at the end of the term for which coverage is purchased, requiring less credited hours, and the student was enrolled in this Plan as a full-time student immediately preceding spring or fall term) Visiting Scholars, Optional Practical Training students and formal English as a Second Language program students with an F1 or J1 visa are eligible to enroll in this insurance Plan. The six-credit hour requirement is waived for summer if the applicant was enrolled in this plan as a full-time student in the immediately preceding spring term.

Students must actively attend classes for which coverage is purchased with the exception of International Visiting Scholars or those engaged in an Optional Practical Training Program. Home study, correspondence and online courses do not fulfil the eligibility requirements that the student actively attend classes. The Insurer maintains its right to investigate eligibility or student status and attendance records to verify that the Plan eligibility requirements have been met. If the Insurer discovers the eligibility requirements have not been met, its only obligation is to refund premium.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse and Dependent children under 26 years of age.

Dependent eligibility expires concurrently with that of the insured student.

U.S. citizens are not eligible for coverage as a student or a Dependent.

2.2 Application and Effective Date

The Master Policy on file at the school becomes effective at 12:01 a.m., July 1, 2018. The individual student's coverage becomes effective the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., June 30, 2019. Coverage terminates on the date or at the end of the period through which premium is paid, whichever is earlier. Twelve (12) months is the maximum time coverage can be effective under any Plan year for any insured person. Dependent coverage will not be effective prior to that of the insured student or extended beyond that of the insured student.

Benefit changes are not permitted during the Plan year. Any benefit changes to a Certificate are subject to the previous Certificates Waiting Periods and Pre-Existing Conditions Limitations.

2.3 Pre-Existing Conditions Limitations

This Plan provides coverage for Pre-Existing Conditions on the following basis:

- Student: Pre-Existing Conditions are covered upon enrollment without a Waiting Period.
- Dependent spouse and children: Pre-Existing Conditions are covered upon satisfaction of a 24-month Waiting Period.

2.4 Addition of a Newborn Baby or Legally Adopted Child

Born Under a Pregnancy Covered by the Maternity Benefit or Adopted as of the Date of Birth: Such babies are automatically covered during the first 31 days of life. All regular Deductible, Coinsurance and plan Copayments will apply. In order to continue the baby's benefits after 31 days, the Plan Participant will:

- Provide written notification to the Insurer within 31 days of the date of birth. In the case of an adopted child, a copy of the legal adoption papers is required. The newborn child shall be accepted from the date of birth, for full coverage according to the terms of the plan, regardless of health status,
- The newborn baby will be enrolled for the same coverage as the Plan Participant.

Any request received beyond the 31-day notification period shall result in coverage only being effective from the date of notification. Coverage is not guaranteed and is subject to submission of a Health Statement.

Born When a Plan Participant is Not Covered by the Maternity Benefit: Newborn babies, that are born and the Plan Participant is not covered by the maternity benefit under this plan, may be covered subject to the following:

- The Plan Participant will provide written notification to the Insurer (Official Copy of Birth Certificate), and
- A Health Statement must be submitted detailing the medical history of the child,
- Coverage will become effective as of the date of notification, provided the Insurer has approved the Health Statement, Coverage is not guaranteed and is based upon the health of the newborn baby,
- Any applicable Pre-Existing Condition limitation will apply.

2.5 Addition of a Legally Adopted Child After the Date of Birth

A child adopted after the date of birth may be covered providing the following applies:

- The child must be up to 19 years old, and
- The Plan Participant will provide written notification to the Insurer (an official copy of the legal adoption papers is required with the notification), and

- A Health Statement must be submitted detailing the medical history of the child.

Coverage will be contingent based upon the terms and conditions of the plan. Additionally,

- Coverage will become effective as of the date of notification, and
- Any applicable Pre-Existing Condition limitation will apply.

3.0 PREMIUM, CANCELLATION, AND POLICY PROVISIONS

3.1 Premium Payment

All Premiums are payable before coverage is provided.

3.2 Cancellation

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

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

If the Plan Participant cancels the insurance coverage after it has been issued, or reinstated the Insurer will not refund the unearned portion of the Premium.

3.3 Rate Modifications

The insurance coverage term begins on the Effective Date as shown on the Medical Identification card. The maximum length for the Period of Insurance can be no longer than 365 days. The coverage is not subject to guaranteed issuance or renewal.

3.4 Duration of Coverage

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

3.5 Compliance with the Plan Terms

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

3.6 Fraudulent/Unfounded Claims

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

3.7 Privacy

The confidentiality of information is of paramount concern to GBG Insurance Limited, Global Benefits Group, Inc., and their affiliates ("GBG Family of Companies"). GBG Family of Companies complies with Data Protection Legislation, Medical Confidentiality Guidelines, and Privacy Shield. The Insurer does not share information unless it pertains to the administration of the benefits for Plan Participants. For more detailed information, Our privacy policy can be viewed on Our website at **https://www.gbg.com/#/AboutGBG/PrivacyPolicy**.

3.8 Waiver

Waiver by the Insurer of any term or condition will not prevent us from relying on such term or condition thereafter.

3.9 Denial of Liability

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

4.0 GEOGRAPHIC AREAS OF COVERAGE

4.1 Areas of Coverage

The plan is written on a Worldwide basis, excluding Home Country.

4.2 Preferred Provider Network

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

United States only:

- **Preferred Provider In-Network:** This tier consists of all Providers as well as other preferred Providers designated by the Insurer and listed on the website. In-Network Providers have agreed to accept a 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 an Allowable Charge as determined by the Insurer. The Provider may bill the Plan Participant the difference between the amounts reimbursed by the Insurer and the Provider's billed charge. Additionally, the Plan Participant will pay a Coinsurance amount that is higher than if an In-Network Provider were used.
- **Out-of-Network Area:** When there are no network providers located within a 30 mile radius of your local residence, charges from such providers will be treated the same as a U.S. Preferred Provider In-Network.

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

5.0 PRE-AUTHORIZATION REQUIREMENTS AND PROCEDURES

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

The following services require Pre-Authorization:

- Any Hospitalization;
- Outpatient or Ambulatory Surgery;
- All Cancer Treatment (Including Chemotherapy and Radiation);
- Prescription medications in excess of $3,000 per refill; and
- Air Ambulance – Air Ambulance service will be coordinated by Insurer's air ambulance provider;
- Any condition, which does not meet the above criteria, but are expected to accumulate over $10,000 of medical treatment per policy year.
- Durable Medical Equipment expected to accumulate over $10,000 in costs per policy year.

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

Medical Emergency Pre-Authorizations must be received within 48 hours of the Admission or procedure. In instances of an emergency, you or the Plan Participant should go to the nearest hospital or provider for assistance even if that hospital or provider is not part of the Network.

Pre-Authorization approval does not guarantee payment of a claim in full, as additional Copayments and Out-of-Pocket expenses may apply. Benefits payable under the plan are still subject to eligibility at the time charges are actually incurred, and to all other terms, limitations, and exclusions of the plan.

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

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

The plan covers Plan Participants for Allowable Charges for covered medical expenses, in the area of coverage covered under this plan. Benefits will be paid on a Usual, Customary, and Reasonable basis, subject to the plan exclusions, limitations, and conditions if they are:

- Insured as a result of an Illness or accidental bodily Injury, under the care of a Physician, and
- Medically Necessary,
- Ordered by a Physician, and
- Delivered in an appropriate medical setting.

6.0 HOSPITALIZATION AND INPATIENT BENEFITS

6.1 Accommodations

Coverage is provided for room and board, special diets, and general nursing care. All charges in excess of the allowable semi-private rate are the responsibility of the Plan Participant. Intensive Care Unit benefits will be provided based on the Allowable Charge for Medically Necessary Intensive Care services.

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:

- Admission to the hospital was pre-authorized, or was deemed to be an eligible medical emergency by GBG Assist; or
- 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 the determination of the patient's medical status.

Inpatient hospital confinements primarily for purposes of receiving non-acute, long term custodial care, respite care, chronic maintenance care, or assistance with Activities of Daily Living (ADL), are not eligible expenses.

6.2 Medical Treatment, medicines, laboratory, diagnostic tests, and ancillary services

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

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

Physical and Occupational therapy must be rendered by a Physician, registered physical/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
- Provide 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
- Support the establishment of an effective maintenance program.

6.3 Inpatient Consultation by a Physician or Specialist

The 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. Insurer will require submission of records and other documentation of the medical necessity for the intensive services.

6.4 Extended Care Facility Services, Skilled Nursing and Inpatient Rehabilitation

Benefits are available 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. A confinement includes all approved extended care facility Admissions not separated by at least 180 days.
- Rehabilitation for patients who require such care because of a covered Illness, disability or Injury.

7.0 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 for the following:

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

7.1 Physician Visits

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

7.2 Outpatient Diagnostic Testing

The Insurer provides benefits for diagnostic testing including echocardiography, ultrasound, MRI, and other specialized testing, to diagnose an Illness or Injury.

7.3 Therapeutic Services

The 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. Services must be pursuant to a Physician's written treatment plan, which contains short and long term treatment goals and is provided to Insurer for review. The following services must either:

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

8.0 SURGICAL BENEFITS

8.1 Surgical Services

The Insurer will provide benefits for covered surgical services received in a Hospital, a Physician's office or other approved facility. Surgical services include; use of operation room and recovery room, operative and cutting-procedures, treatment of fractures and dislocations, surgical dressings, and other Medically Necessary services.

8.2 Anesthesia Services

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

8.3 Reconstructive Surgery

Reconstructive surgery as a result of an Accident or Illness will be covered as long as it is determined that it is Medically Necessary.

9.0 EMERGENCIES

9.1 Emergency Room

Benefits are provided for life threatening emergency services when incurred in a Hospital's emergency room. Admission to the Hospital is not required for benefit consideration. Within the United States, use of the emergency room for non-emergency services is a costly alternative and all services provided may not be eligible for benefit payment.

9.2 Emergency Ground Ambulance Services

Benefits are provided for Medically Necessary emergency ground ambulance transportation to the nearest Hospital able to provide the required level of care. The use of ambulance services for the convenience of the Plan Participant will not be considered a covered service.

9.3 Emergency Dental

This includes Emergency Dental treatment and restoration of sound natural teeth required as a result of an Accident. All treatment must be completed within 120 days of the Accident or before the expiration date of the plan. Routine dental treatment is not covered under this benefit.

10.0 MATERNITY CARE

The following maternity benefits are covered and are applicable to any condition related to pregnancy, including but not limited to childbirth, prenatal, miscarriage, premature birth, and complications of pregnancy. Fertility/infertility services, tests, treatments, drugs, and/or procedures, complications of that pregnancy, delivery, postpartum care, and care or treatment for an individual acting as a surrogate including delivery of the child are excluded from coverage. The following benefits are only available to the Plan Participant or Spouse.

10.1 Physician and Obstetrical Services

The Insurer provides the following maternity related benefits:

- Obstetrical and other 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;
- All pre-natal and post-natal Physician's office visits, laboratory and diagnostic testing;
- Pre-natal vitamins are covered during the term of the pregnancy only, if prescribed by a Physician.

10.2 Newborn Infant Care Services

Hospital nursery services and medical care provided by the attending Physician for newborn infants in the Hospital are covered. 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 satisfaction of the Policy Year Deductible and Coinsurance. Refer to section 2.5 Addition of a Newborn Baby.

10.3 Complications of Pregnancy

Health complications as a result of pregnancy are subject to the Maximum Benefit per Period of Insurance and not the Maximum Benefit under Maternity.

11.0 OTHER MEDICAL BENEFITS

11.1 Allergy Testing and Treatment

Benefits are provided for specific allergy testing and allergy immunotherapy that is medically necessary with clinically significant allergic symptoms. Coverage is provided for testing and treatment including allergy serums and injections administered in a Physician's office.

11.2 Home Health Care including Nursing Services

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

11.3 Mental Health Benefits

Benefits are provided for psychotherapeutic treatment and psychiatric counseling and treatment for an approved psychiatric diagnosis. Benefits are for both inpatient mental health treatment in a Hospital or approved facility and for outpatient mental health treatment. A Physician or a licensed clinical psychologist must provide all mental health care services.

Services include treatment for Bulimia; Anorexia; Bereavement; non-medical causes of insomnia; Attention Deficit Disorder (ADD); and Attention-Deficit Hyperactivity Disorder (ADHD). The following services do not meet the criteria established by the Insurer for consideration under this benefit:

1. Services for conditions not determined by Insurer as to be emotional or personality Illnesses;
2. Psychiatric services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation;
3. Services for mental disorders or Illness which are not amenable to favorable modification.

11.4 Transplant Services (Human Organ, Bone Marrow, Blood & Stem cell)

Medically Necessary blood, organ, or cell transplants and services may be covered. In the United States, the use of the Institutes of Excellence for Transplants approved by GBG is mandatory. This transplant benefit begins once the need for transplantation has been determined by a Physician and has been certified by a second surgical or medical opinion, and includes:

- Pre-transplant care, including those services directly related to evaluation of the need for transplantation, evaluation of the insured for the transplant procedure, and preparation and stabilization of the insured for the transplant procedure.
- Pre-surgical workup including all laboratory and X-ray exams, CT scans, Magnetic Resonance Imaging(MRI's), ultrasounds, biopsies, scans, medications and supplies.
- The hospitalization, surgeries, Physician and surgeon's fees, anesthesia, medication and any other treatment necessary during the transplant procedure.
- Post-transplant care including, but not limited to any Medically Necessary follow-up treatment resulting from the transplant and any complications that arise after the transplant procedure, whether a direct or indirect consequence of the transplant.
- Medication or therapeutic measures used to ensure the viability and permanence of the transplanted organ, cell or tissue.
- Home healthcare, nursing care (e.g. wound care, infusion, assessment, etc.), emergency transportation, medical attention, clinic or office visits, transfusions, supplies, or medication related to the transplant.

Donor search and donor medical services are not covered under the transplant benefit. Storage of bone marrow, stem cell, or other tissue or cell, and all expenses for cryopreservation of more than 24 hours are also excluded.

11.5 Pediatric Dental Services

Benefits are provided for Covered Dental Services for a Plan Participant under the age of 19.

Diagnostic Services:

- Intraoral Bitewing Radiographs (Bitewing X-ray)
  Limited to 1 series of films per 12 months
- Panorex Radiographs (Full Jaw X-Ray) or Complete Series
- Radiographs (Full Set of X-Rays)
  Limited to 1 time per 36 months
- Periodic Oral Evaluation (Checkup Exam)
- Limited to 2 times per 12 months. Covered as a separate benefit only if no other services was one during the visit other than X-rays.

Preventive Services:

- Dental Prophylaxis (cleanings)
  Limited to 2 times per 12 months
- Fluoride Treatments
  Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.
- Sealants (Protective Coating)
  Limited to once per first or second permanent molar every 36 months
- Space Maintainers (Spacers)
  Benefit includes all adjustments within 6 months of installation

Minor Restorative Services, Endodontics, Periodontics, and Oral Surgery:

- Amalgam Restorations (Silver Fillings)
  Multiple restorations on one surface will be treated as a single filling.
- Composite Resin Restorations (Tooth Colored Fillings)
  For Anterior (front) teeth only
- Endodontics (Root Canal Therapy)
- Periodontal Surgery
  Limited to one quadrant or site per 36 months per surgical area
- Scaling and Root Planing (Deep Cleanings)
  Limited to 1 time per quadrant per 24 months
- Periodontal Maintenance (Gum Maintenance)
  Limited to 4 times per 12 month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement
- Simple Extractions (simple tooth removal)
  Limited to 1 time per tooth of lifetime
- Oral Surgery, including Surgical Extraction

Adjunctive Services:

- General Services (including Dental Emergency treatment)
- Covered as a separate benefit only if no other service was done during the visit other than X-rays
- General anesthesia is covered when clinically necessary
- Occlusal guards limited to 1 guard every 12 months

Major Restorative Services:

- Replacement to complete dentures, fixed, or removable partial dentures, crowns, inlays, or onlays previously submitted for payment is limited to 1 times per 60 months from initial or supplemental placement
- Inlays/Onlays/Crowns (Partial to Full Crowns)
  Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.
- Fixed Prosthetics (bridges)
  Limited to 1 time per 60 months. Covered only when a filling cannot restore the tooth.
- Removable Prosthetics (Full or partial dentures)
  Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments
- Relining and Rebasing Dentures
  Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.

Implants:

- Implant Placement
  Limited to 1 time per 60 months
- Implant Supported Prosthetics
  Limited to 1 time per 60 months

- Implant Supported Prosthetics
  Limited to 1 time per 60 months
- Implant Maintenance Procedures
  Includes removal of prosthesis, cleansings of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.
- Repair Implant Supported Prosthesis by Report
  Limited to 1 time per 60 months
- Abutment Supported Crown (Titanium) or Retainer Crown for FPD-Titanium
  Limited to 1 time per 60 months
- Repair Implant Abutment by Support
  Limited to 1 time per 60 months
- Repair Implant Abutment by Support
  Limited to 1 time per 60 months
- Radiographic/Surgical Implant by Report
  Limited to 1 time per 60 months

Medically Necessary Orthodontics
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy, or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefit are not available for comprehensive orthodontic and/or having horizontal/vertical (overjet/overbite) discrepancies.

All orthodontic treatment must be Pre-Authorized.

Orthodontic Services:

- Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be Medically Necessary.

11.6 Urgent Care

Facility or clinic fee billed by the Urgent Care Center. All other services rendered during the visit will be paid as specified in the Schedule of Benefits.

11.7 Voluntary HIV Screening

Benefits will be paid for the cost of a voluntary HIV screening test performed on an Insured while the Insured is receiving emergency medical services, other than HIV screening, at a hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the Medical Emergency which caused the Insured to seek emergency services. Benefits include one emergency department HIV screening test, the cost of administering such test, all laboratory expenses to analyze the test, the cost of communicating to the Insured the results to the test and any applicable follow-up instructions for obtaining healthcare and supportive services.

11.8 Elective Abortion

Benefits are provided for elective abortions if performed at a licensed facility and meets the guidelines of the state where performed.

11.9 Preventive Care

Child Wellness: This includes well-child routine medical exams, health history, development assessments, immunizations, and age related diagnostic tests covered up to the age of 12 months.

Adult Wellness: This includes routines physical examinations, immunizations for infectious diseases as recommended by the Center for Disease Control and preventive medical attention.

Adult Female Screenings

The following exams are included.

- Routine Mammogram
  - Ages 35-39: One baseline exam
  - Ages 40-49: One exam every one or two years
  - Age 50 and beyond: One exam annually
  - Any Age: When Necessary
- Papanicolaou (PAP) Screening: One exam annually

Adult Male Screenings

The following exams are included.

- PSA Screening Test: Ages 50 and beyond, one test annually

11.10 Habilitative Services for the Treatment of Congenital or Genetic Birth Defects

Benefits will be paid the same as any other Illness for Habilitative Services for the treatment of Congenital or Genetic Birth Defects for a Plan Participant to age 21 years. Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the plan.

For the purpose of this benefit:
Congenital or Genetic Birth Defect means a defect existing at or from birth including a hereditary defect including autism or an autism spectrum disorder or cerebral palsy.

Habilitative Services include occupational, physical, and speech therapy for the treatment of a child with a Congenital or Genetic Birth Defect to enhance the individual's ability to function.

11.11 Diabetic Medical Supplies

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

11.12 HIV/AIDS

Benefits are available for Medically Necessary, non-experimental services, supplies and drugs for the treatment of Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV +), AIDS Related Complex (ARC), sexually transmitted diseases and all related conditions.

11.13 Durable Medical Equipment

Insurer provides benefits for prosthetic devices (artificial devices replacing body parts), orthopedic braces and equipment including wheelchairs and hospital beds. Such Durable Medical Equipment (DME) must be:

- Prescribed by a Physician, and
- Customarily and generally useful to a person only during an Illness or Injury, and
- Determined by Insurer to be Medically Necessary and appropriate.

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

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

- Comfort items such as telephone arms and over bed tables;
- Items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers;
- Miscellaneous items such as exercise equipment, heat lamps, heating pads, toilet seats, bathtub seats,
- The customizing of any vehicle, bathroom facility, or residential facility.
- Devices for sports or improvement of athletic performance and power enhancement or power controlled devices, nerve stimulators, and other such enhancements to prosthetic devices.

11.14 Alcohol and Substance Abuse

The benefit includes inpatient and outpatient services including diagnosis, counseling, and other medical treatment rendered in a Physician's office or by an outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by or under the clinical supervision of a licensed Physician or a licensed psychologist who certifies that the Plan Participant needs to continue such treatment.

11.15 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 covered, even if a Physician prescribes it.

11.16 Hospice Care Program

Hospice is a program approved by Insurer to provide a centrally administered program of palliative and supportive services to terminally ill persons and their families. Terminally ill refers to the patient having a prognosis of 240 days or less. Covered services are available in home, outpatient and inpatient settings. The Hospice care guidelines are:

- Must relate to a medical condition that has been the subject of a prior valid claim with the Insurer, with a diagnosis of terminal Illness from a medical doctor;
- Benefit is payable only in relation to care received by a recognized hospice.

11.17 Professional Sports and other Hazardous Activities

The plan covers **leisure sports and activities** 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. Examples of such covered activities include but are not limited to; kayaking, snorkeling, paddle boarding, sailing, white water rafting levels 1-3, and scuba diving up to 15 meters.

This plan does not cover **hazardous or extreme sports and activities, professional sports and activities, intercollegiate, and interscholastic sports.**

11.18 Medical Evacuation/Repatriation

***Reimbursement of Emergency Air Ambulance (Medical evacuation)*:** The cost of a person accompanying a Plan Participant is covered under this plan, with expenses subject to pre-approval by GBG Assist. GBG Assist retains the right to decide the medical facility to which the Plan Participant shall be transported and the means of transportation. Approved medical evacuations will be to the nearest medical facility capable of providing the necessary medical treatment. The Plan Participant is required to contact GBG Assist for Pre-Authorization before a Plan Participant incurs any evacuation and assistance costs using any means of transportation. If the Plan Participant fails to follow these conditions, he will be liable for the full costs of any transportation.

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.

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

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

11.19 Return of Mortal Remains

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

11.20 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 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 plan must be inforce.

- Loss of a Hand or Foot means complete severance through or above the wrist or ankle joint.
- Loss of Sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.
- Severance means the complete separation and dismemberment of the part from the body.

Exclusions and Limitations: The Insurer shall not be liable for:

1. 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.
2. 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.

11.21 War and Terrorism

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

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

12.0 HOW TO FILE A CLAIM

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

12.1 Medical and Prescription Drug Claims

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

Claims may be submitted to the Insurer directly by the Provider or Facility. The Insurer will process the claim according to the Schedule of Benefits and plan terms, and remit payment to the health care provider. Ineligible charges or those in excess of the Allowable Charges will be the responsibility of the Plan Participant. If the Plan Participant has paid the health care provider, the Plan Participant will submit the claim form along with the original paid receipts directly to the Insurer. Photocopies will not be accepted unless the Claim is submitted electronically. The Insurer will reimburse the Plan Participant directly according to the Schedule of Benefits and plan terms.

Prescription Drug Claims

If you have purchased a prescription **in the U.S., using an In-Network pharmacy**, you should have paid a copayment for your prescription. The pharmacy will bill GBG directly for the prescription and there is no claim filing necessary by you.

12.2 Accidental Death and Dismemberment Claims

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

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

12.3 Reimbursement Options

Claims reimbursements will be made by:

- Electronic Direct Deposit for Plan Participant where the receiving bank is located in the U.S.,
- Wire Transfer for members and overseas providers where the receiving bank is located outside of the U.S., or
- Check sent to member or provider where electronic payment is not possible.

12.4 Settlement of Claims

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

If the plan has an Out-of-Pocket maximum, once it is met the plan will begin paying 100% of Allowable Charges for the remainder of insurance coverage, subject to the benefit maximums.

12.5 Status of Claims

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

12.6 Releasing Necessary Information

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

12.7 Coordination of Benefits

It is the duty of the Plan Participant to inform Insurer of all other coverage. In no event will more than 100% of the Allowable Charge and/or maximum benefit for the covered services be paid or reimbursed.

If a Plan Participant has coverage under another insurance contract, including but not limited to health insurance, worker's compensation insurance, automobile insurance (whether direct or third party), occupational disease coverage, and a service received is covered by such contracts, benefits will be reduced under this plan to avoid duplication of benefits available under the other contract. This includes benefits that would have been payable had the Plan Participant claimed for them. The following guidelines will be used to determine the primary plan:

- The Plan is Primary if it covers the claimant as an active Insured.
- If two Plans cover the claimant as an Insured, the Plan that has covered him for the longer period of time is the Primary plan.
- If a Plan Participant is covered as an active Insured under the Plan and as a retired or laid off Insured under another Plan, the Plan that covers him as an active Insured is the Primary Plan. The Plan that covers him as a retired or laid off Insured is the Secondary Plan.

12.8 Sanctions

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

12.9 Subrogation

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

13.0 CLAIMS APPEAL

13.1 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-service or current care coverage has been denied; you or your appointed representative has the right to file an appeal within 180 days.

Your appeal will be reviewed and the decision made by a member of the claims staff who was not included in the original decision. Appeals involving Medical Necessity, clinical appropriateness, or experimental and investigational treatments will be considered by a health care professional.

For Level One Appeals regarding required pre-service or concurrent care coverage decision, GBG will respond with a decision within 15 calendar days. We will respond within 30 calendar days for appeals regarding a post service coverage decision. If more time or information is needed to make the decision, GBG will notify you to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

13.2 Level Two Appeal

If you are dissatisfied with the Level One appeal decision, you may request a Level Two Appeal. To start, 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 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 notify you that we have received your request and schedule a Committee Review. For required pre-service 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.

13.3 Independent Review Procedure

If you are not satisfied with the final decision of the Level Two appeal review, 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, 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 plan.

There is no charge for you to initiate this Independent Review process. The Insurer 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 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 180 days of your receipt of the Insurer's final adverse benefit determination. The Insurer will then forward the file to the Independent Review Organization. The Independent Review Organization will render an opinion within 30 days of request.

13.4 Expedited Appeals

You may request that the appeal process be expedited if, 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 your appeal involves non-authorization of an Admission or continuing inpatient stay. GBG Medical Review Agent in consultation with the treating Physician will decide if an expedited review is necessary. When an appeal is expedited, GBG will respond within 72 hours, followed up in writing or electronically within five days.

13.5 Complaints Procedure

If you are not satisfied with the outcome of the Appeals process as described above, you may file a formal complaint. The complaints procedures are listed at GBG's website: https://www.gbg.com/#/AboutGBG/ComplaintsProcedures.

14.0 EXCLUSIONS AND LIMITATIONS

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

1. Acne;
2. Assistant Surgeon Fees;
3. Milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or mental retardation;
4. Injections;
5. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children;
6. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
7. Elective Surgery or Elective Treatment;
8. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a covered Injury or disease process;
9. Health spa or similar facilities; strengthening programs;
10. Hearing examinations; hearing aids; or cochlear implants; or other treatment for hearing defects and problems, except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
11. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;
12. Injury or Illness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
13. Injury or Illness inside the insured's home country;
14. Injury or Illness outside the United States and its possessions, Canada or Mexico, except when traveling for academic study abroad programs or pleasure to or from the insured's home country;
15. Injury or Illness when claims payment and/or coverage is prohibited by applicable law;
16. Injury sustained while

a. participating in any interscholastic, intercollegiate, or professional sport, contest or competition;
b. traveling to or from such sport, contest or competition as a participant; or
c. while participating in any practice or conditioning program for such sport, contest or competition;

17. Investigational services;
18. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
19. Prescription Drugs, services or supplies as follows;
    a. Therapeutic devices or appliances, including: hypodermic needles, syringes, suppo1t garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy;
    b. Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;
    c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
    d. Products used for cosmetic purposes;
    e. Drugs used to treat or cure baldness; anabolic steroids used for body building;
    f. Anorectics - drugs used for the purpose of weight control;
    g. Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
    h. Growth hormones; or
    i. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
20. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
21. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the policy;
22. Routine Newborn Infant Care, well-baby nursery and related Physician charges; in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;
23. Preventive care services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Illness; except as specifically provided in the policy;
24. Services provided normally without charge by the Health Service of the institution attended by the Insured; or services covered or provided by a student health fee;
25. Temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic purulent sinusitis;
26. Sleep disorders;
27. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
28. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
29. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and
30. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat, except as specifically provided in the policy.

Pediatric Dental Exclusion: In addition to the Exclusions and Limitations shown above, the following exclusions also pertain to the Pediatric Dental Exclusions:

1. Any Dental Service or Procedure not listed in the Schedule of Benefits for Pediatric Dental Services.
2. Dental Services that not necessary.

3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly relation to provider error. This type of replacement is the responsibility of the Dental Provider If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular (TMJ), wither bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment with giving the dental office 24 hours' notice.
15. Expenses for Dental Procedures begun prior to the Plan Participant's Effective Date of coverage.
16. Dental Services otherwise covered under the plan, but rendered after the date of individual coverage under the plan terminates, including Dental Services for dental conditions arising prior to the date
17. Services rendered by a provider with the same legal residence as the Plan Participant or who is a member of the Plan Participant's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.

15.0 DEFINITIONS

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

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

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

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

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

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

Allowable Charge: The fee or price the Insurer determines to be the Usual, Customary and Reasonable Charges for health care services provided to Plan Participants. The Plan Participant is responsible for the payment of any balance over the Allowable Charge (except in the U.S. when a Preferred Provider has delivered the service, then there is no balance due). All services must be Medically Necessary. Once an allowable charge is established then the Deductible, Coinsurance, Copayments and any excess charges must be paid by the Plan Participant.

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

Birth Center: 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.

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

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

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

Complications of Pregnancy: A condition:

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

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

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

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

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

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

Custodial Care: Includes: (1) the provision of room and board, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, as determined by the individual's attending Physician, has reached the maximum level of recovery; and (2) in the case of an institutionalized person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be expected that medical or surgical treatment will enable him to live outside an institution; and (3) rest cures, respite care and home care provided by family Insureds. Upon receipt and review of a claim, the Insurer or an independent medical review will determine if a service or treatment is Custodial Care.

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

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

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

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

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

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

GBG Assist: The customer service division of the Insurer. They provide, 24/7 assistance service to answer any customer needs around the world, including emergency evacuation, benefit coordination, locating a network provider, and Pre-Authorization of medical services.

Habilitative Service: Occupational therapy, physical therapy, and speech therapy for the treatment of a child with a Congenital or Genetic Birth Defect to enhance the Plan Participant's ability to function.

Hazardous or Extreme Sports: 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.

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

Home Country: The country from which the Plan Participant holds a passport. In the event that a citizen of the United States holds more than one passport, the United States shall be deemed the Home Country.

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

Home Health Care Plan: A program: 1) for the care and treatment of a Plan Participant in his home; 2) established and approved in writing by his attending Physician; and 3) Certified, by the attending Physician, as required for the proper treatment of the Injury or Illness, in place of inpatient treatment in a Hospital or in an Extended care Facility.

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

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

Injury: Accidental bodily harm sustained by a Plan Participant that results directly and independently from all other causes from a Covered Accident.

Illness: A physical Illness, disease, pregnancy and complications of pregnancy of a Plan Participant. This does not include Mental Illness.

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

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

Master Policy: The agreement between the Insurer and the International Benefit Trust.

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

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

Medically Necessary: 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 as follows:

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

Non-Emergency/Non-Emergent Care: A condition in which a prudent person recognizes that a change in their health has taken place via on-set of Illness or Accident but is not considered a life threatening Medical Emergency but feels a medical intervention would be the proper course of action.

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

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

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

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

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

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

Pre-Existing Condition: 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 Allowance: Refers to the amount an In-Network provider will accept as payment in full for covered medical expenses.

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

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

Prescription 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.

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

Provider: 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.

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

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

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

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

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

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

The Usual, Customary, and Reasonable 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.

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

16.0 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 "Insurer") to Plan Participants under the Trust (the "Coverage"). I understand that the Coverage is not a general health insurance product, but is intended for use in the event of a sudden and unexpected event while traveling outside my Home Country (for purposes of this Agreement, Home Country means the country from which the Plan Participant holds a passport. In the event that a citizen of the United States holds more than one passport, the United States shall be deemed the Home Country). I understand that the Coverage extended to me will terminate upon my return to my Home Country unless I qualify for a benefit period or Home Country coverage. I understand that I may obtain full details of the Coverage by requesting a copy of the master policy from Global Benefits Group, Inc. (the "Plan Manager"). I understand that the liability of the Insurer as underwriter of the Coverage is as provided in the master policy.

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

The Plan Participant undertakes to make all premium payments as they fall due in respect of the Coverage extended. ITA Global Trust Ltd (the "Trustee") shall not be responsible for the administration of such payments.

If the Plan Participant fails to make any premium payment due in respect of the Coverage extended, subject to the discretion of the Insurer, such Coverage will lapse.

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

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

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

Insured By:

GBG Insurance Limited

Administered By:
Global Benefits Group
27422 Portola Parkway, Suite 110
Foothill Ranch, CA 92610 USA