Safe Travels Schengen Visa Summary of Coverage

Plan is underwritten by BULSTRAD LIFE VIENNA INSURANCE GROUP JSC

Policy Number: **STSV-52018**

Member ID: 999999999

Covered Person: John Q. Traveler

Member DOB: 2/5/1958

Home Country: IN

Premium Paid: 1,500

Effective Date: 8/26/2018

Termination Date: 10/15/2018

Destination(s): US

If you have questions about your coverage or to renew please contact your agent:

Crossborder Services, LLC 877-340-7910

SCHEDULE OF BENEFITS	
Coverage	**Benefit Limits**
1. Emergency Medical Evacuation • Accompaniment - Maximum Benefit $300 per day / $6,000 total • Continuation • Repatriation for Medical Treatment	100% up to $150,000
*2. Emergency and Accidental Medical Treatment • All coverage subject to Usual and Customary Limits • Preferred Provider Networks when available for Direct Payment • Acute/emergency Illness and Injury • Treatment by authorized physicians, nurses and specialists • Hospitalization (semi-private rooms) • Surgery, anesthesiologist • Prescribed medicines, dressings • Local transport to and from the place of treatment • Treatment by physiotherapists and chiropractors up to $2,500 • Medically necessary required durable medical equipment • Emergency dental treatment for immediate relief of pain up to $500 • Repatriation to home country upon medical stabilization This policy does NOT cover: (See policy terms, conditions and exclusions) × Treatment of Pre-existing conditions × General or preventative medical conditions × Chronic or recurring Illnesses and disorders	100% up to $50,000
3. Repatriation of Mortal Remains	100% up to $20,000
4. 24/7 Emergency Assistance via GBG Assist	Unlimited
*Some limitations apply. Coverage paid at Usual and Customary.	

GENERAL TERMS OF COVER

1. Please check Schedule of Benefits and policy wording to fully determine benefits covered by your policy.

2. This policy is compliant with European Schengen and visa requirements for most countries. Entry requirements change frequently, please check with your respective country of destination about visa and entry requirements.

3. Trip Maximum Issuance: Maximum duration not to exceed 180 days and may not be combined with any other policy to exceed this limit.

4. Contiguous policy, extensions and refund of days:
   a. While traveling: No policy shall be issued in conjunction with the expiry of another policy.
   b. Single Trip Policies: A one-time policy extension may be granted per policy without a holding period if requested 72-hours prior to the expiry of the period of insurance. Extensions within 72-hours are subject to a claims holding period up to a maximum of three days after the expiry of the original period of insurance.
   c. No extensions will be approved for anyone above age 70.
   d. No extensions will be approved beyond a cumulative 180-day period.
   e. Refunds are not issued for unused days and a policy may not be extended more than 1 time.

5. Children/Dependent Coverage:
   a. Children's rates apply to dependent children from ages 14 days-16 years and are contingent upon travelling with a covered adult. The policy MUST be issued in conjunction with the parent/guardians GBG policy.
   b. Children's policies MUST be purchased at the same time as the parent/guardians policy or they will be charged at the adult rate (17-39 age band)
   c. Unaccompanied children traveling on their own may purchase the policy from age 5 onward at the 17-39 adult rate.

6. The insured person should not take out this policy if the intent is to live in fixed location outside (Living abroad versus traveling) their home country of residence.

7. Maximum Age: Premium calculations will be age at inception and have not attained age 70 at the time of enrollment. The policy will cease at the first renewal date following an Insured Person's 70th birthday.

8. All claims must be submitted within 90 days from date of incident or they will be denied. Circumstances may exist in which this is not always possible. Any submissions after 90 days will be considered based on those circumstances.

9. All claims arising under this insurance shall be governed by the Laws of Bulgaria, whose courts alone shall have jurisdiction in any dispute arising hereunder.

10. If the Insured Person or any person acting on his/her behalf shall make any claim or statement knowing the same to be false or fraudulent as regards amount or otherwise, then this Insurance shall become void and all claims here under shall be forfeited without refund of premium.

11. The Insurer may at their own expense take proceedings in the name of the Insured Person to recover compensation or secure an indemnity from any third party in respect of any loss, damage or expense covered by this Insurance and any amounts, recovered or secured shall belong to the Insurer.

12. Benefits and premiums in this policy may be denominated in US Dollars, British Pounds or Euros, and benefits will be stated in the same currency in which the premium is paid.

13. Client must notify Plan Administrator within 30 days of a change of address or domicile. PLEASE NOTE A CHANGE OF ADDRESS MAY AFFECT YOUR ELIGIBILITY UNDER THIS POLICY. Example: Any Insured person who moves to a new country WILL NO LONGER BE COVERED in the NEW COUNTRY OF DECLARED RESIDENCE.

POLICY TERMS AND CONDITIONS

Benefits are applicable when the Insured Person is outside his or her Home Country of permanent residence; coverage also is in effect when traveling from and to their home country as part of an international trip.

1. **Emergency Medical Evacuation**: The plan covers the reasonable and customary charges for emergency evacuation when medical treatment is not available locally and deemed necessary and pre-approved by GBG Assist (the insurer), their medical advisors and the attending Physician–to a suitable location that will render immediate and appropriate care which may or may not be the home country of origin. If the Insured does not obtain pre-approval from GBG Assist, GBG reserves the right to deny coverage or apply substantial co-payments for the associated costs to a maximum of 50% the evacuation cost.

1.1 Accompaniment: The insurance allows for the travel and accommodation expenses of one person (i.e., a relative or friend who is a resident of Insured Person's home country), whom upon medical advice is advised to join, accompany, remain with or escort the Insured Person. Transportation costs will be by commercial carriers and in economy class. Maximum Benefit $300 per day/$6,000 total.

1.2 Continuation: Upon pre-approval of GBG Assist, coverage includes transportation by economy travel for the Insured Person, if medically able, to the point of initial destination to continue with the trip.

1.3 Repatriation For Medical Treatment**:** GBG reserves the right to review and repatriate any case in which the Insured Person is medically stable and upon advice of the Insurers and Attending Medical Doctors can be evacuated at GBG's discretion to the home country of residence and any form of treatment or surgery which in the same medical opinion can be delayed until the Insured Person returns to their home country. Refusal to accept repatriation when medically stabilized can result in the insurer denying further medical coverage and benefits.

2. **Emergency and Accidental Medical Treatment:** The PRIMARY PURPOSE of this Travel Policy is to protect an Insured Person from acute, sudden and unforeseen Medical and Accidental Emergencies. It is not intended to care for general medical conditions or Pre-existing conditions and is subject to the limits specified in the Schedule of Benefits.

2.1 This may include usual, customary and reasonable expenses incurred by the Insured Person in case of acute/emergency Illness and injury. Policy covers required treatment by authorized physicians, nurses and specialists, hospitalization (semi-private rooms) including surgery, anesthesiologist, prescribed medicines, dressings and local transport to and from the place of treatment shall be compensated at 100% of the expenses. Treatment by physiotherapists and chiropractors prescribed by an authorized physician shall be compensated at 100% of the expenses, not to exceed $2,500. Including emergency dental treatment for the immediate relief of pain $500 maximum. The insurance shall not cover expenses for treatment of Pre-existing, chronic or recurrent Illnesses and disorders or unnecessary durable medical devices/equipment. See exclusions below.

2.2 Outpatient services are covered per the policy and may be utilized via Urgent Care Centers and only via licensed medical doctors.

2.3 Coverage will continue until such time as when, in the opinion of the doctor in attendance and the Insurers' medical advisers, the Insured Person is fit to travel provided that these all occur within 12 months of the date of the incident (outside Home Country).

2.4 Event: Any one incident in which the Insured Person requires care for acute, sudden and unforeseen Medical and Accidental Emergencies and the direct consequence of the event. Multiple events independent of each other are covered to the event maximum with no limits on the number of events. This policy is for Emergency Care and stabilization only. In the event of a long-term Illness or diagnosis the Insured Person will not be covered for treatment or ongoing care or extended care for that Illness or injury.

2.5 Repatriation for Medical Treatment: GBG reserves the right to review and repatriate any case in which the Insured Person is medically stable and upon advice of the Insurers and Attending Medical Doctors can be evacuated at GBG's discretion to the home country of residence and any form of treatment or surgery which in the same medical opinion can be delayed until the Insured Person returns to their home country. Refusal to accept repatriation when medically stabilized can result in the insurer denying further medical coverage and benefits.

2.6 Excess Insurance Provision: The insurance provided under both Medical and Evacuation shall be in excess of all other valid and collectable insurance or indemnity and shall apply only when such other benefits are exhausted. In the event no other insurance coverage exists, this coverage becomes primary with GBG reserving the right to review and potentially subrogate with any undeclared coverage whether known or unknown to the Insured Person.

3. Repatriation of Mortal Remains:

3.1 A benefit for either repatriation of mortal remains or local burial is included in this policy. This benefit excludes fees for return of personal effects, religious or secular memorial services, clergymen, flowers, music, announcements, guest expenses and similar person burial preferences.

3.2 All Repatriation benefits and the necessary clearances for the return of an Insured Person's mortal remains by air transport to the Home Country must be coordinated and pre-approved by GBG Assist.

4. 24/7 Emergency Assistance via GBG Assist: GBG Assist is available 24 hours a day, 7 days a week, providing assistance on: Pre-Authorization of medical services; Emergency and assistance services; Locating an In-Network Provider; General customer services; Medical Evacuation handling and coordination; Repatriation for medical treatment; Repatriation of Mortal Remains coordination; Medical Case Management and review. GBG Assist requires notification as soon as possible for all situations requiring emergency medical treatment. Medical Emergency Pre-Authorizations must be received within 24 hours of the admission or procedure. In instances of an emergency, the Insured Person should go to the nearest Hospital or provider for assistance even if that Hospital or provider is not part of the Network. Failure to do so will result in a 50% reduction in payment of Covered expenses. For services that result in evacuation or repatriation, GBG Assist **must** be notified. Contact **GBG Assist** for emergency assistance.

DEFINITIONS

Please note certain words used in this document have specific meanings.

1. **"Accident"** means a sudden, unexpected and unintended event where the Insured Person sustaining bodily Injury caused by accidental, external, violent and visible means which shall solely and independently of any other cause
2. **"Acute / Medical Conditions"** means defined as a sudden and unexpected Illness occurring after you have started your trip abroad. In order for a Illness to be covered it must be unexpected and non-preexisting and stable for the last 12 months prior to departure and if left untreated could cause deterioration in an Insured Persons condition.
3. **"Automobile"** means a self-propelled, private passenger motor vehicle with four or more wheels that is a type both designed and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, sport utility vehicle, or a motor vehicle of the pickup, van, camper, or motor-home type. Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.
4. **"Covered Expenses"** means expenses actually incurred by or on behalf of an Insured Person for treatment, services and supplies covered by the Policy. Coverage under the Policy must remain continuously in force from the date of the Accident or Illness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

5. **"Covered Trip"** means a period of round-trip travel away from the Insured Person's Home Country; the trip has defined departure and return dates specified when the Insured enrolls.
6. **"Deductible"** means the dollar amount of Covered Expenses that must be incurred as an out of-pocket expense by each Insured Person on a per Policy Term basis before Medical Expense Benefits and/or other Additional Benefits paid on an expense incurred basis are payable under the Policy.
7. **"Dependent"** means an Insured's lawful spouse or Domestic Partner; or an Insured's unmarried child, from the moment of birth (14 days for this policy) to age 21, who is chiefly dependent on the Insured for support. A child, for eligibility purposes, includes an Insured's natural child; adopted child, beginning with any waiting period pending finalization of the child's adoption; or a stepchild who resides with the Insured or depends chiefly on the Insured for financial support.
8. **"Doctor"** means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to an Insured Person that is appropriate for the conditions and locality. It will not include an Insured Person or a Insured Person of the Insured Person's Immediate Family or household.
9. **"Event":** Any one incident in which the Insured Person requires care for acute, sudden and unforeseen Medical and Accidental Emergencies and the direct consequence of the event. Maximum coverage is limited to amounts specified in the Schedule of Benefits. Multiple events independent of each other are covered to the event maximum with no limits on the number of events
10. **"Family Insured Person"** means the spouse, parent, parent-in-law, grandparent, child, grandchild, brother, sister, fiancée, such person being resident in the Home Country (as declared on the application), of the Insured Person, or of the person with whom the Insured Person is travelling or had arranged to travel.
11. **"Home Country"** means a country from which the Insured Person holds a passport. If the Insured Person holds passports from more than one country, his or her Home Country will be that country which the Insured Person has declared to us in writing as his or her Home Country.
12. **"Hospital"** means an institution that: 1. operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2. provides 24-hour nursing service by Registered Nurses on duty or call; 3. has a staff of one or more licensed Doctors available at all times; 4. provides organized facilities for diagnosis, treatment and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5. is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such; and 6. Is not a place solely for drug addicts, alcoholics, or the aged or any separate ward of the Hospital.
13. **Illness:** A physical sickness, disease, pregnancy and complications of pregnancy. This does not include mental Illness.
14. **"Injury"** means accidental bodily harm sustained by an Insured Person that results directly and independently from all other causes from a Covered Accident. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, and are considered a single Injury/event.
15. **"Insured Person"** means any Insured and Dependent for whom the required premium is paid and a person in a Class of Eligible Persons for whom the required premium is paid making insurance in effect for that person. A Dependent covered under the Policy is not an Insured, but rather a Dependent.
16. **"Medical Emergency"** means a condition caused by an Injury or Illness that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.
17. **"Medically Necessary"** means a treatment, service or supply that is: 1. required to treat an Injury or Illness; prescribed or ordered by a Doctor or furnished by a Hospital; 2. performed in the least costly setting required by the Insured Person's condition (usual, reasonable and customary); and 3. Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.
18. **"Period of Insurance"** means the dates as shown on your certificate for which premium has been paid;
19. "**Pre-Existing Condition:"** means any Illness or Injury, physical or mental condition, for which a Insured Person received any diagnosis, medical advice or treatment, or had taken any prescribed drug, or where distinct symptoms were evident prior to the Effective Date. A Pre-Existing Condition is considered stable, which in the twelve months before the Effective Date, there have not been: new/change in treatment; medical management; medication including a change in dosage, and new/more frequent/more severe symptoms or findings, and new test results or test results showing a deterioration, and investigations initiated or recommended for your symptoms, and hospitalization or referral to a specialist.

20. "**Traveling Companion"** means a person or persons with whom you have coordinated travel arrangements, shares the same accommodations as You and intend to travel with during the Trip.
21. **"Trip"** means travel by air, land, or sea from the Insured Person's Home Country.
22. **"Usual, Customary, and Reasonable"** means 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 Illness or Injury 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.

GENERAL EXCLUSIONS

Unless specified in the Benefits Schedule, in any written endorsement, or agreed by Company in writing, no claim can be made for compensation or payment for damage or expenses caused by or as a result of the following:

1. Pre-Existing **Conditions:** All treatment and expenses for routine care and maintenance related to Pre-Existing medical conditions.
2. In respect of Accidental Damage to Natural Teeth, no benefit is payable for Injury caused by eating or drinking (even if it contains a foreign body), normal wear and tear, tooth brushing or any other oral hygiene procedure or any means other than extra-oral impact, any form of restorative or remedial work, the use of precious metals, orthodontic treatment of any kind or dental treatment performed in a hospital unless dental surgery is the only treatment available to alleviate pain.
3. Suicide or attempted suicide, intentional self-injury, the effect of intoxicating liquors or drugs.
4. Treatment of hernia, Osgood-Schlatter disease, osteochondritis, osteomyelitis, pathological fractures, congenital weakness whether or not caused by a Covered Accident.
5. Evacuation costs where the Insured Person is not being admitted to a Hospital for Treatment or where costs have not been approved by The Company prior to travel commencing.
6. Any costs arising after expiry of the current Period of Insurance.
7. Any form of treatment or surgery which in the opinion of the Doctors(s) in attendance and GBG Assist can be delayed until your return to your home country.
8. Any treatment for HIV / AIDS related conditions or Illnesses whether pre-existing or diagnosed during or immediately after a covered period under this insurance.
9. Any expenses incurred after you have returned to your Home Country.
10. Medical Expenses in excess of a limit stated in the Benefits Schedule.
11. The amount of the Policy Excess, Deductible or Co-Payment, as stated on the Certificate of Insurance.
12. Any cost resulting in an Illness, Injury or death from the misuse of drugs or being under the influence or effect of alcohol (other than a legally prescribed medication by a licensed medical professional).
13. Needless self-exposure to peril except in an attempt to save human life.
14. Intentional or fraudulent acts on the Insured Person's part or their consequences.
15. Trips specifically made for the purpose of obtaining medical treatment.
16. Cosmetic surgery or remedial surgery, removal of fat or other surplus body tissue and any consequences of such Treatment, weight loss or weight problems/eating disorders, whether or not for psychological purposes, unless required as a direct result of an accident which occurs during the Period of Insurance.
17. Treatment for alcoholism, narcotics, drug and substance abuse/dependency or any addictive condition of any kind and any injury or Illness arising from the Insured Person being under the influence of alcohol, drugs or any other intoxicating substance.
18. Pregnancy, childbirth whether normal or complicated, including the transfer of a pregnant woman to hospital to give routine childbirth or air travel when the Insured Person is more than 20 weeks pregnant and was NOT a result of an accident or onset of complications relating from an accident.

19. Treatment for mental or nervous disorders, including transitional life events, homesickness, fatigue, jet-lag or work-related stress; the costs of psychotherapists, psychologists, family therapists or bereavement counselors.

20. Use of any type of firearm(s). (Defined as any device that discharges a projectile of any type).

21. Any expenses relating to search and rescue operations to find an Insured Person in mountains, at sea, in the desert, in the jungle and similar remote locations including air/sea rescue charges for evacuation to shore from a vessel or from the sea.

22. Charges or fees incurred for the completion of medical claim forms.

23. Expeditions, and mountaineering and or trekking above 3500M or 11,500 feet is considered an extreme sport and not covered, included and not limited to:

a. Expeditions to Mt Everest, K2, Kilimanjaro, Antarctica, the Arctic, North Pole and Greenland.

24. Motorcycle vacations or holidays of any kind.

25. The radioactive, toxic, explosive or other hazardous or contaminating properties of any nuclear installation, reactor or other nuclear assembly or nuclear component thereof.

26. War Insurrection and Terrorism: The Insurer shall not be liable for:

Nuclear, and Weapons of mass destruction: means the use of any explosive nuclear weapon or device or the emission, discharge, dispersal, release or escape of fissile material emitting a level of radioactivity capable of causing incapacitating disablement or death amongst people or animals.

Chemical Weapons: mass destruction means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing incapacitating disablement or death amongst people or animals.

Utilization of Biological weapons of mass destruction means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which are capable of causing incapacitating disablement or death amongst people or animals.

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

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 Insured Person by reason of their eligibility for benefits under the Plan, the Insurer has a right to equitable restitution. The Insurer will subrogate with any coverage whether known or unknown to the Insured Person.

CLAIMS PROCEDURES

Claims must be filed within **90 days** of treatment/loss 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 the Insurer and are processed in the order in which they are received. 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 Insured Person.

If the Insured Person has paid the health care provider, the Insured Person 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 Insured Person directly according to the Schedule of Benefits and Plan terms.

In order for claims to be considered under this Plan claims must be In a form acceptable to the Insurer, and Contain complete supporting documentation. If the Insurer requests additional information from either the Insured Person, Physician, or other party to evaluate the claim and such information is not submitted, the claim will be denied.

Reimbursement Options: Claims reimbursements will be made by: a) Electronic Direct Deposit for Insured Person where the receiving bank is located in the U.S., b) Wire Transfer for Insured Persons and overseas providers where the receiving bank is located outside of the U.S., or c) Check sent to Insured Person or provider where electronic payment is not possible.

Status of Claim:
To request the status of a claim or have a question please call: USA and Canada 877-916-7920
Outside the United States and Canada, call direct or collect: 949-916-7941 or customerservice@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.

Claims forms are available at http://www.trawickinternational.com/resources/claim-forms
For a list of providers visit: http://www.trawickinternational.com/resources/healthcare-provider-search

RELEASING NECESSARY INFORMATION

It may be necessary for the Insurer to request a complete medical file on an Insured Person 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 Insured Person.

CLAIMS APPEAL

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; the Insured Person or your appointed representative has the right to file an appeal within 90 days. Your appeal will be reviewed and the decision made by an authority on 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 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.

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.

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.

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.

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*.

ACCESSING AND ADMINISTERING YOUR BENEFITS VIA NETWORK PROVIDERS

PREFERRED PROVIDER NETWORK

The Company maintains a Preferred Provider Network both within and outside the United States. Within the United States, the Company recommends the use of the Preferred Provider Network for maximum benefit payment. Please visit **www.GBG.com** for a complete list of providers.

International / Schengen Countries: The Insured Person may utilize any licensed Provider. However, we suggest the Insured Person to 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.

Plan Administrator
Trawick International
PO Box 2284 Fairhope AL 36533
Toll Free: 888-301-9289 Direct: 251-661-0924 Fax: 251-666-1806
Email: info@trawickinternational.com

Claims Administrator-EU
GBG Vienna
Attn: Safe Travel Claims
Fillgradergasse 7/8
A-1060 Vienna Austria
Email: eclaims@gbg.com

Emergency Assistance via GBG Assist
Available 24 hours a day, 365 days a year
Email: gbgassist@gbg.com
Toll free within the United States and Canada: 877-916-7920
Worldwide Collect: 949-916-7941 or 905-669-4920
Fax: (949) 271-2330

This policy is insured by:
BULSTRAD LIFE VIENNA INSURANCE GROUP JSC
6, Sveta Sofia Str.
1301 Sofia, Bulgaria